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DOCUMENT VERSION CONTROL

Version	Date Released	Summary of Changes
2019.01	04/19/19	**Initial Release**
2019.02	05/10/19	• Added instructions for Reports 0902, 0903, 0905 and 0906. • Added Report 0906 to the Table of Contents. Adjusted pagination in the Table of Contents. • Changed the instructions in Report 0201 Item 4 to be Item 3 divided by Item 1. It had been Item 3 divided by Item 2. The report template has also been changed. • Changed the instructions in Report 0201 Item 11 to be Item 10 divided by Item 2. It had been Item 10 divided by Item 1. The report template has also been changed • Changed the instructions in Report 0301 Item 4 to be Item 3 divided by Item 1. It had been Item 3 divided by Item 2. The report template has also been changed. • Changed the instructions for Report 0602 related to Concurrent Review to change processing time from "within 24 hours" to "within 1 business day". • Changed the verbiage in the Purpose for Report 0703 to indicate it is for all HIP business lines, not just HIP Basic. • Changed the instructions for Report 0705 to no claims lag. Previously, it had stated a claims lag. The Report Catalog has also been changed in Excel. • Changed the title of Report 0803 from "Capitation Rate Calculation Sheet" to "Encounter Data". • Changed the periodicity of Report 0806 to quarterly. It has previously always been quarterly but had inadvertently changed to annual version 2019.01. The Report Catalog has also been changed in Excel.
2020.01	6/5/2020	**2020 Revision**
		• Added Reports 0509, 0704, 0707 and 0708 to the list of Priority Reports. • Removed the Gateway to Work verbiage from reports 0201, 0202 and 0802. • Included: ▪ The reporting submission requirements (submission location, extension request, and resubmission protocols). ▪ The process of obtaining SharePoint access. ▪ The naming convention of reports due monthly and annually. ▪ Fines/liquidated damages. • The Report 0510 has been separated into 3 reports. The template has also been updated.

		• Changed the instruction for Report 0602 related to Concurrent Review to change the processing time from "within 1 business day" to "within 1 business day after receiving all necessary information to make a decision". • Changed in Report 0703 the list of preventive services. The list was mapped, and the Appendix C has also been updated. • Added to Reports 0902 and 0903 the taxonomy code for "hematology oncology" to the "hematology" category so the MCEs may count these providers as well in determining member and network access for hematology services. • Changed the submission date in Report 1101 from five (5) to ten (10) business days. • Changed the submission location of Reports 1101 and 1102. The MCEs are to place the Reports under the HIP folder. • Adjusted the pagination in the Table of Contents
2020.02	9/4/20	**2020 Revision**
		- Updated the Fines/Liquidated Damages. - Corrected the formula in Reports 0201,0505,0708,0710 and 0906. - Modified the instructions/template in Report 0202 and added the requirements related to SMI/SED services and providers. - Modified the template in Reports 0506 and 0803 to allow the MCEs to add more data elements. - Updated the list of OMPP approved IMDs in Report 0510 and changed the length of stay for SUD-related conditions to from 15 to 30 days. - Modified Reports 0601a& 0603 and changed the Category of Authorization from "All other Except SUD" to "All Other". The Appendix B has been updated. - Included Reports 0803 and 0804 on the Comments tab. - Included Report 0906 on the Catalog tab. - Corrected the naming of Reports 1002 and 1003 on the quarterly template. - Updated the template/instructions in Report 1103. - Updated the instructions/templates in Reports 1202 &1203 - Adjusted the pagination in the Table of Contents.
2021.01	5/11/21	**2021 Revision**
		- Predefined the quarter-year (#13) on the quarterly attestation form until CY 2022. - Updated the instructions/template in Report 0101 to include the volume or readjudicated claims. - Modified the instructions in Report 0102 to require the count of total claims rather than claims lines. - Updated the items numbers in Report 0202. - Updated Report 0401 to Include:

		▪ The members 30 Months old Who Had Two or More Well-Child Visits During the last 15 Months (W30). ▪ The Comprehensive Well Child Visits with a PCP or OBGYN in the Third through twenty-one Years of Life (WCV). ▪ The Childhood Immunization Status (CIS) measures. - Updated Report 0402: ▪ Changed the Medication Management for people with Asthma (MMA) to the Asthma Medication Ratio (AMR) measure. ▪ Added the Annual Dental Visit (ADV) measure - Updated the template in Report 0511 to match the instructions. - Updated Reports 0601,0602,0603 and 0603 to include authorizations denied for medical necessity and those denied for administrative issues. - Updated the Key Staff list in Report 0801 - Included the Termination Date tab in Report 0802. - Updated the templates in Reports 0902 and 0903 in HCC to include Pediatric Dentistry (specialty 274) and Opioid Treatment Providers (specialty 835). - Adjusted the pagination in the Table of Contents.
2021.02	6/30/21	**2021 Revision**
		- Added the naming convention of Ad hoc Reports - Updated verbiage in the Version Control on File Submissions - Updated the Fines/Liquidated Damages to reflect the current HHW, HIP and HCC Contracts. - Updated the attestations in the quarterly and annual templates. - Updated Appendix C - Added an appendix E- Diagnosis Codes Included on the Managed Care Health Plans Emergency Department Autopay Lists Reviewed/Updated: January 1, 2021. - Added a new report 0305 - Timeliness of Requests to Join Provider Network. - Corrected formulae in Reports 0101,0302,0402,0503,0510,0601,0602,0603,0604.0605 and 0906. - Removed in Report 0402 the MPM measure and changed the AAP age range. - Updated the names of Reports 0503,0504 and 0705. - Updated Report 0510: o Added a drop-down menu o Updated the list of OMPP approved IMDs - Corrected the verbiage in Reports 0604,0709,1101 and 1102. - Changed the periodicity of Report 0806 - Adjusted the pagination in the Table of Contents.

2022.01	5/26/2022	**2022 Revision**
		– Predefined the quarter-year (#13) on the quarterly attestation form until CY 2023. – Updated the verbiage in Report 0101 to define rejected Pharmacy claims – Updated the verbiage in Report 0203 to include "member and provider requests". – Added a new report 0205-Enhanced Services Program. – Updated the Timeliness of Requests to Join Provider Network Report 0305. – Updated the HEDIS Report 0401: ▪ Well-Child Visits in the First 30 Months of Life measure (W30) replaces the members 30 Months old Who Had Two or More Well-Child Visits During the last 15 Months. ▪ Child and Adolescent Well-Care Visits measure (WCV) replaces the Comprehensive Well Child Visits with a PCP or OBGYN in the Third through twenty-one Years of Life. - Updated the age stratification in the WCV measure to align with the MY 2022 HEDIS specifications. – Updated HEDIS Report 0402: ▪ Revised the Prenatal and Postpartum Care (PPC) measure specifications. - Changed to postpartum care to visit that occurred on or between 7 and 84 days after delivery. - Changed the continuous enrollment to 43 days prior to delivery through 60 days after delivery - Updated the experience periods ▪ Initiation and Engagement of Substance Use Disorder Treatment (IET) replaces Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence. ▪ Follow-Up After ED Visit for Substance Use (FUA) replaces Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence. ▪ Revised terminology from "Alcohol or other Drug Abuse or Dependence (AOD)" to Substance Use Disorder (SUD) or any diagnosis of Drug Overdose." – Updated Appendix B to reflect the current codes. – Updated appendix E- Diagnosis Codes Included on the Managed Care Health Plans Emergency Department Autopay Lists Reviewed: October 1, 2021.
		- Added Sickle Cell Disease to the list of Conditions of interest in Reports 0514 and 0515. - Updated the verbiage in Report #0601 to align with the contract requirements. - Renamed Report #1001 to Quality Management Improvement work plan (QMIP)and Quality Improvement Projects (QIP) Quarterly Updates, updated instructions and included the QMIP/QIPs flowchart.

		- Renamed Report #1002 to Prospective and Retrospective Quality Management and Improvement Work Plan (QMIP) and updated instructions. - Adjusted the pagination in the Table of Contents.
2023.01		**2023 Revision**
		- Updated contact information for Program Evaluation Manager and Quality Reporting Analyst - Updated wording in #0102 to reflect 2021 change of "detail lines" to "count of total claims" - Added a line to report the count of grievances, expedited appeals, and non-expedited appeals received in the quarter regardless of resolution status in #0202* - Added line to report total number of requests for hearings in the quarter in #0203* - Added #0206 Annual Report* - Updated language in # 0201, #0301, and #0302 instructions to clarify attempted returns of after-hours calls. - Replaced ADV with OED and CDC with HBD in #0402 - Deleted #0509 Weeks of Pregnancy report to match NCQA. - Updated list of IMDs in #0510 - Updated #0703 Preventative Exam (Rollover Related) to report number of members who earned a premium reduction and asks for distribution of members by subpopulation* - Added items in #0706 to report details of PAC contributions and additional member detail* - Added columns to report #0707 additional contribution detail and member information by Federal Poverty Level and aid categories* - Combined #0709 and #0710 to new #0709 Non-Payment of POWER Account Contributions & Collectible Debt* - Added Chief Information Officer or Information Technology Director, Dental Manger, Member Advocate/Non-Discrimination Coordinator, and Health Equity Officer to the list of staff in report #0801 - Updated provider types and access requirements in report #0902 and #0903 to reflect 2023 HIP/HHW contract. - Updated #1001 to require quarterly Quality Improvement Work Plan updates. - Changed templates and instructions for quarterly QIP updates. This is now report #1002 and utilizes the QSource/OMPP template and instructions. Appendix D was updated with instructions for the new template. - Updated QMIP/QIP Flowchart - Added reports #1006 (Quality Management and Improvement Program Description) and #1007 (Quality Management and Improvement Program Evaluation) - Replaced items 9A-9D in report #1103 to improve iterative useability. - Deletion of the 1201 report

		*These updates reflect the Ad Hoc submission from Fall 2022-March 2023
2023.02		**2023 Revision 2**
		- Definition of Informal Dispute in #0303 revised to align with IAC - "Delegated Provider" added as a Reason for Effective Date in #0305 - #0510 template updated to version created between MCEs and Federal Reporting team in spring 2023 - Timeliness standards in #0601 updated for July 2023 legislative change - #0703 references to appendix removed. Specifications for report updated. - DCS Liaison added on #0801 for HCC - Instructions for #0803 updated to align HCC with HIP/HHW - Appendix E (ED Auto Pay List) updated with the revised July 2023 version

INTRODUCTION

This serves as the instructions and specifications for managed care entities (MCEs) to submit the reports that comprise the **MCE Reporting Manual**. The entire Reporting Manual was updated in the Spring of 2019 with consultation between OMPP Quality and Operations staff, MCE Reporting staff and MCE subject matter experts.

The majority of the reports utilize a template developed by the OMPP that is native to Excel. There are five workbook files that contain templates:

- Quarterly templates (reports submitted on a quarterly basis)
- Annual templates (reports submitted on an annual basis)
- Quality templates (reports specific to quality initiatives, some are quarterly submissions, and some are annual submissions)
- Program Integrity templates (reports specific to program integrity, one report is monthly, two are quarterly, and one is an annual submission)
- FQHC/RHC templates (reports specific to payments to federally qualified health centers and rural health centers, one report is monthly and two are annual submissions)

In the future, the MCEs will be asked to provide electronic data files to support the report submissions.

Additionally, there are five Appendices:

- Appendix A provides more specification related to information submitted on Report 0507
- Appendix B provides more specification related to information submitted on Reports 0601, 0602 and 0603
- Appendix C provides more specification related to information submitted on Report 0703
- Appendix D is the template for Quality Improvement Program (QIP) annual evaluations
- Appendix E provides more specification related to information submitted on Reports 0503,0504,0507 and 0705

Color Coding Used in the Reporting Manual

In the Quarterly Report workbook specifically, color-coding has been applied to indicate column headings and cells in each report:

	Pre-defined column headings
	Explanatory text
	Hoosier Healthwise columns
	Healthy Indiana Plan columns
	Hoosier Care Connect columns
	Fields that the MCE is to fill in
	Fields that the MCE would normally fill in but are not applicable to a particular program
	Calculation fields
	Validation fields

Report Catalog

The Report Catalog appears in both the Table of Contents of this document as well as a tab at the front of the Quarterly Report workbook. In the Quarterly Report workbook, additional information provided about each report includes:

- The report number assigned in CY 2022
- If the report existed in prior Reporting Manuals, the former Report Abbreviation
- The submission periodicity
- The report deadline
- An indication if there is a claims lag applicable to the report
- The template type for the report
- If the template is an OMPP Excel template, which template file the report is located
- An indicator if this is an OMPP Priority Report

INSTRUCTIONS ON SUBMITTING REPORT TEMPLATES

General Reporting Submission Requirements

For effective contract oversight, OMPP relies heavily on the reports submitted by the MCEs to monitor contract compliance, plan operations and quality outcomes. Strict adherence to naming conventions, file submissions and resubmissions is required. This allows OMPP to fairly compare MCEs, as well as overall program performance. To ensure proper and consistent submission of reporting materials, the MCEs must utilize the most current version of the reporting manual. **Reports must be submitted timely, completely and accurately in the specified formats for the reporting periods and entered into the correct SharePoint file.** OMPP may consider the MCE's reporting data as not received, not received on time or inaccurate if the MCE submits reporting data in templates or formats not approved by OMPP.

An MCE may submit report data earlier than the actual date the data is due. However, **OMPP will consider the data late if OMPP does not receive the data electronically in the designated SharePoint site and email boxes by 5:00 pm (Indianapolis time; Eastern Standard Time) on the date due.** If the deadline falls on the weekend or state holiday, it is due the first business day following the deadline. An MCE may request a reasonable extension on reporting submissions by emailing the Program Evaluation Manager (jennifer.darmelio@fssa.in.gov**) and the Reporting Analyst (drake.ruley@fssa.in.gov).** The Program Evaluation Manager and/or will notify the MCE if the extension request is accepted or denied.

If the MCE fails to provide report data as required, OMPP may consider the plan noncompliant and may assess liquidated damages or other remedies as described in the applicable Contract.

Report Submission Location

An OMPP SharePoint site will act as the repository for MCE data submissions. The MCE must submit all reporting data to OMPP using the following SharePoint site:

https://ingov.sharepoint.com/sites/FSSAPortal/ompp/managed%20care

The file upload must be accompanied with an email message to the Program Evaluation Manager (jennifer.darmelio@fssa.in.gov) and the Reporting Analyst (drake.ruley@fssa.in.gov) with a copy of the signed attestation.

If there is an issue with the site, the MCE may also submit a copy of the reports to the program email address: ManagedCare@fssa.in.gov

Within the SharePoint site, OMPP has set up file folders for housing the performance reports. The SharePoint site file structure is designed to make the reporting data readily available for contract management. MCE staff will be provided access to the SharePoint sub-site by program and plan. Each MCE is fully responsible for placing their report data in the appropriate folder location for access and review by OMPP. **Adherence to naming conventions, file submissions and re-submissions is required.**

To determine the proper placement of data, MCEs must follow the general rule that data should be placed in the folder for which the data is due. The plan should utilize the report catalog to verify report deadlines. The SharePoint site will time and date stamp uploaded information for tracking purposes.

The SharePoint site structure is as follows:

1. Each MCE will be able to view the program sub-site.
2. In the sub-site, each MCE will be able to view a titled MCE tab. Each health plan will have limited access to its own program/plan tab.
3. Along the left-hand side, in the content box for each tab will be a link for Shared Documents. Once the MCE clicks on the Shared Document link, the plan will immediately view folders for each year.
4. Once the appropriate year is selected, there will be Monthly sub-folders viewable for selection. An additional folder to retain all External Quality Review documents for that year is available. For quarterly and annual data, the sub-folder is annotated for quick reference.

Reports are to be placed under the **HIP program** within each monthly sub-folder.

5. A document can then be uploaded to the appropriate folder in the requisite naming conventions described later in this document. To upload documents, click on either "New" or "Upload" by following the instructions provided at the site.

Submission example: Initial submission of 2022 Quarter 1 health data (HHW, HIP, and HCC) due in April. Drilldown the following path:

- (sub-site) HIP
- (tab) "Health Plan"
- (folder) 2022
- (sub-folder) 04 April (Q 01)
- (excel file) MCE's name2022Q1.01

Obtaining SharePoint Access:

Prior to staff being granted SharePoint access, a new account access form must be completed. The form may be completed at the following location by OMPP staff:

https://myshare.in.gov/FSSA/dts/AccountControl/AccountControl/

In order to complete the form accurately, the following information should be received:

- Managed Care Entity
- Employee First, Last Name
- Employee Telephone number
- Employee Email address
- Staffing Title
- Address Information

- Company, Department
- Access needed: Read only, or Contributor

This information will then be added to the form. VPN and Citrix access are not required to be a SharePoint member. Once the form is complete, the user id and password assigned are emailed to the Program Evaluation Manager designated as the "Manager" by the Indiana Office of Technology (IOT). The Program Evaluation Manager adds the individual to the SharePoint site then distributes the login information to the new user. (If the staff is added to the State's Global Address List, the "alias" assigned as the network address will be the network id for the SharePoint site.)

To modify or delete access for MCE staff, an email request is to be sent to your assigned policy analyst, or the Reporting Manager. Access requests may be made available within five business days.

If the password needs to be reset, users should contact the IOT helpdesk at (317) 234-4357.

If an account has been disabled due to inactivity, contact the Program Evaluation Manager. The Program Evaluation Manager will send an email to fssaaccountcontrol@fssa.in.gov for reinstatement.

Version Control on File Submissions

In the Quarterly Report workbook, MCEs are instructed to enter the Quarter-Year that pertains to the reports being submitted in the file on the Attestation file next to the MCE's name. This information is then transferred to each report in the template.

If it is the initial submission of the workbook, the nomenclature for submitting the Quality Report workbook is as follows:
MCE yearQ#.01 Quarterly
where
MCE = the MCE's name
Year = the year related to report submissions
Q# = Q1, Q2, Q3, or Q4 depending upon which quarter the reports are being submitted for
.01 is the version number
Quarterly indicates the workbook type

Please note: the naming of the 0803 should reflect the quarter of submission. Although it is not submitted at the same time as other quarterly reports, it should follow the quarterly nomenclature.

The nomenclature for submitting the Monthly Reports is as follows:

MCE year month version number report number line(s) of business
Where
MCE= the MCE's name
Year = the year related to report submissions
Month= the month related to report submission
Version number = the initial submission (.01), resubmission (.02) etc.
Report number = the appropriate report code as stated in the manual
Lines of Business = the appropriate program the report applies to (HHW, HIP, and HCC).

The nomenclature for submitting Ad Hoc Reports is as follows:

MCE year month report number line(s) of business
Where
MCE= the MCE's name
Year = the year related to report submissions
Month= the month related to report submission
Version number = the initial submission (.01), resubmission (.02) etc.
Report number = the appropriate report code as stated in the manual
Lines of Business = the appropriate program the report applies to (HHW, HIP, and HCC).

Naming Convention of Reports due Annually

The nomenclature for submitting reports due annually is as follows:
MCE AN Year Version number Report Number Line(s) of Business.
Where
MCE= the MCE's name
AN= the frequency indicator which means that this is an annual report
Year= the year related to report submission
Version number = the initial submission (.01), resubmission (.02) etc.
Report number = the appropriate report code as stated in the manual
Lines of Business = the appropriate program (HHW, HIP, and HCC).

Submission Example: Initial submission of the Annual Program Integrity Plan Report (#1104) due in January 2022 for all lines of business.
The file name for this submission is**: MCE's name AN 2021 01 1104 HIP HHW HCC**

On the Attestation forms, the MCE is instructed to enter the submission date next to every report that is being submitted in the workbook. Dates should be shown for HHW, HIP, and HCC separately. Use the v1 column to enter these dates.

After submission, if OMPP or the MCE determines that information has been omitted or is inaccurate, amended data may be requested and accepted. The OMPP Program Evaluation Manager (jennifer.darmelio@fssa.in.gov) and OMPP Reporting Analyst (drake.ruley@fssa.in.gov) should be contacted upon discovery.

If the MCE needs to resubmit reports after version .01, then the MCE should do the following:

1. Start with the .01 Excel file that you submitted.
2. Do a 'Save As' and rename the file by replacing .01 with .02.
3. Change the Attestation form by changing the Date of Submission of the .02 file.
4. Enter the new date that indicates the resubmission date in the v2 columns, but ONLY enter a date in the specific reports that are being updated. Do not enter a date in any cell for a report that is not being updated. That is an indicator to the reader that no changes were made to these reports.
5. Repeat this process if a .03 version of the file is necessary.

Any resubmission must be uploaded to the State's SharePoint side in the same folder as the original submission.
The file upload must be accompanied with an email message to **Program Evaluation Manager (jennifer.darmelio@fssa.in.gov) and the Reporting Analyst (drake.ruley@fssa.in.gov)** indicating:

- The name of the report(s) being resubmitted
- The reporting period to which the data applies
- The version number.
- The line(s) of business.

An example of this is shown on the next page.

Example shown below
The 0201, 0202 and 0203 reports for 2nd Quarter were all submitted on schedule for all programs on 7/31/19.
The file name for this submission is: [MCE]2019Q2.01

		Use the following column:			Use the following column:			Use the following column:		
		for v1 file	for v2 file	for v3 file	for v1 file	for v2 file	for v3 file	for v1 file	for v2 file	for v3 file
Report #	**Report Name**	**Hoosier Healthwise**			**Healthy Indiana Plan**			**Hoosier Care Connect**		
0201	Member Helpline Performance	07/31/19			07/31/19			07/31/19		
0202	Member Grievances and Appeals	07/31/19			07/31/19			07/31/19		
0203	Independent External Reviews and FSSA Hearings	07/31/19			07/31/19			07/31/19		

The MCE needed to make updates to the 0202 report, but only for HHW and HIP. The update was submitted on August 10, 2019.
The file name for this submission is: [MCE]2019Q2.02

		Use the following column:			Use the following column:			Use the following column:		
		for v1 file	for v2 file	for v3 file	for v1 file	for v2 file	for v3 file	for v1 file	for v2 file	for v3 file
Report #	**Report Name**	**Hoosier Healthwise**			**Healthy Indiana Plan**			**Hoosier Care Connect**		
0201	Member Helpline Performance	07/31/19			07/31/19			07/31/19		
0202	Member Grievances and Appeals	07/31/19	08/10/19		07/31/19	08/10/19		07/31/19		
0203	Independent External Reviews and FSSA Hearings	07/31/19			07/31/19			07/31/19		

Attestation

The MCE is required to have its CEO, Executive Director, or CFO sign the Attestation form with submission of every report submission. There are two attestation forms. One form is a tab included in the Quarterly Report workbook. This form contains all of the reports in the Quarterly Report workbook. Another form is a separate file that contains all other reports not contained in the Quarterly Report workbook. Utilize either or both Attestation forms with your report submissions depending upon which reports are being submitted at any given time.

Data Validations

The Quarterly Report workbook contains a *Validations* tab. This tab looks up to all validations embedded throughout reports in the workbook. The MCEs should ensure that every cell on the *Validations* tab contains the word "match", "totals match" or "yes". If they do not, then there is a data integrity problem on one or more reports. The OMPP will reject the MCE's submission of the Quarterly Report workbook, even if it is submitted by the due date.

Comments to OMPP

There is a separate *Comments* tab where the MCE can write specific comments pertaining to any report in the Quarterly Report workbook. Issues such as data anomalies, incomplete data, or large changes from prior periods should be included in this tab.

Fines/Liquidated Damages

If Contractor fails to submit in HIP/HHW any report in the MCE Reporting Manual in a timely, complete and accurate manner (other than the HEDIS and CAHPS reports), Contractor shall pay liquidated damages of five thousand, two hundred dollars ($5,200) for each month each report (other than the HEDIS or CAHPS reports) is not submitted in a timely, complete, or accurate manner.

If Contractor fails to submit in HCC any Priority Report in a timely, complete, and accurate manner (other than the HEDIS and CAHPS reports), Contractor shall pay liquidated damages of four thousand, eight hundred and eighty dollars ($4,880) for each Priority Report (other than the HEDIS or CAHPS reports) that is not submitted in a timely, complete, and accurate manner.

If Contractor fails to submit in HHW or HIP a HEDIS or CAHPS report that was based on the National Committee for Quality Assurance (NCQA) methodology for sampling data, Contractor shall pay liquidated damages of five thousand, two hundred dollars ($5,200) for each business day the report is not submitted in a timely, complete, and accurate manner.

If Contractor fails to submit in HCC a HEDIS or CAHPS report that was based on the National Committee for Quality Assurance (NCQA) methodology for sampling data, Contractor shall pay liquidated damages of five thousand two hundred dollars ($5,200) for each business day the report is not submitted in a timely, complete, and accurate manner.

If Contractor fails to submit in HCC in a timely, complete, and accurate manner any report which Contractor is required to provide under the Contract or the Reporting Manual, Contractor will pay liquidated damages of five hundred dollars ($500) per report for each business day for which such report has not been submitted correctly, complete, on time, and in the correct reporting format.

If, during any quarter after the first year of the Contract, Contractor fails to submit Encounter Data Quality reports to FSSA in a timely, complete, and accurate manner, and does not meet the 98% completeness threshold in HHW, HIP or HCC, the Contractor will be assessed liquidated damages of $49,200 **per quarter**, **per program**.

Report Number	**0101**
Report Title	**Report 0101: Claims Adjudication Summary**
Purpose	To assess the MCE's claims processing productivity and timeliness in adjudicating clean provider claims.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	No
Data Reported Each Submission	For submissions April 30: Claims Received or Adjudicated in Period Jan 1 – Mar 31 For submissions July 31: Claims Received or Adjudicated in Period Apr 1 – June 30 For submissions Oct 31: Claims Received or Adjudicated in Period July 1 – Sept 30 For submissions Jan 31: Claims Received or Adjudicated in Period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	**Claim:** A claim is a billing encounter notice submitted for reimbursement consideration or a health care utilization document that itemizes health care service(s) (i.e., claim line items) that have been rendered to a member. **UB-04 Claim:** The nationally recognized **c**laim form approved for the submission for payment of institutional services. Under the Health Insurance Portability and Accountability Act (HIPAA), electronically submitted institutional claims are referred to as 837I claims. Unless specifically indicated otherwise, the term UB-04 is used for either paper or electronically submitted institutional claims. **CMS 1500 Claim:** The nationally recognized claim form for the submission for payment of professional services. Under HIPAA, electronically submitted professional claims are referred to as 837P claims. Unless specifically indicated otherwise, the term CMS 1500 is used for either paper or electronically submitted professional claims. **American Dental Association (ADA) Dental Claim:** The nationally recognized claim form for the submission for payment of professional services. Under HIPAA, electronically submitted dental claims are referred to as 837D claims. **Pharmacy Claim:** The nationally recognized claim form for the submission for payment of pharmacy scripts.

	Clean Claim: A claim in which all information required for processing the claim is on the claim form. **Adjudicated Clean Claim:** An original claim that has been received by the MCE and processed through its claims system to a "paid" or "denied" decision status. Adjudicated clean claims should **NOT** include: • rejected claims • replacement or adjustment claims • misdirected claims • claims for members not currently enrolled • claims for which the MCE is not financially responsible • unclean claims that require additional information • pended or suspended claims **Clean Claim Paid On Time:** For electronically-submitted claims, a clean claim is paid on time when it is paid within 21 calendar days of the MCE's receipt. For paper-submitted claims, a clean claim is paid on time when it is paid within 30 calendar days of the MCE's receipt. **Clean Claim Paid Late:** For electronically-submitted claims, a clean claim is paid late when it is paid more than 21 calendar days after the MCE's receipt. For paper-submitted claims, a clean claim is paid late when it is paid more than 30 calendar days after the MCE's receipt. **Paid Clean Claim:** A paid claim is a billing encounter notice submitted for reimbursement consideration or (health care) utilization documentation that itemizes (health care) service(s) (i.e., claim line items) rendered to a covered person eligible to receive the (health care) service(s) on the date rendered in which at least one of the (health care) services (i.e., a claim line item(s)) is ***either partially or fully*** reimbursable or deemed eligible for full or partial reimbursement if the submitting entity had not been pre-paid for the (health care) service(s). Paid clean claims should not include: • rejected claims • replacement claims • misdirected claims • claims for members not currently enrolled

	• claims for which the MCE is not financially responsible • unclean claims **Denied Clean Claim:** A denied claim is a billing encounter notice submitted for reimbursement consideration or health care utilization documentation that itemizes health care service(s) (i.e., claim line items) rendered to a person in which ALL the health care service(s) (i.e., claim line item(s)) **are deemed NOT eligible/appropriate for reimbursement**. Denied clean claims should NOT include: • rejected claims • replacement claims • misdirected claims • claims for members not currently enrolled • claims for which the MCE is not financially responsible • unclean claims **Unclean Claim:** A claim in which all the information required for processing is not present per IC 12-15-13.0.6. For OMPP reporting purposes this includes claims that were: • Claims received and denied by the MCE because the claim failed to pass HIPAA compliancy edits. These claims will not pass the fiscal agent's pre-adjudication edits for encounter submissions. • Claims that do not have the National Provider Identifier (NPI). These claims are treated as a rejected claim regardless of whether the MCE accepts the claim into its inventory system. • A final decision regarding the service cannot yet be made due to lack of information. **Rejected Claim:** A claim that the MCE cannot accept into its inventory for future adjudication or accepts into its inventory but OMPP has specified should be treated as a rejected claim. Rejected claims should not be submitted to OMPP in the encounter data process. Rejected claims should include the following scenarios: • misdirected claims: a claim submitted to the wrong entity for processing (e.g., claim submitted to the wrong MCE) • claims for members not currently enrolled

- claims for which the MCE is not financially responsible
- unclean claims (a claim in which all the information required for processing is not present – per IC 12-15-13.0.6)

For purposes of this report, rejected claims and unclean claims should be treated the same.

Rejected Pharmacy Claim: A pharmacy claim that, upon adjudication, does not result in a paid claim (a result of R in field 112-AN). For rejected pharmacy claims, the MCEs should use the current National Council for Prescription Drug Programs (NCPDP) Reject Codes.

Please note that the MCEs should report the first rejection the claim receives (a value of 1 in field 546-4F), and all rejections in field 511-FB, not just some.

Please refer to the NCPDP rejection codes for your Pharmacy claims

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER	15 character RxCLAIM number assigned to each transaction	RW	Required if needed to identify the transaction.
51Ø-FA	REJECT COUNT	Count of 'Reject Code' (511-FB) occurrences. Maximum count of 5	R	
511-FB	REJECT CODE	See National Council on Prescription Drug Programs (NCPDP) External Code List.	R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	RW	Required if a repeating field is in error, to identify repeating field occurrence.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Count of the 'Additional Message Information' (526-FQ) occurrences that follow. Maximum count of 9	RW	Required if Additional Message Information (526-FQ) is used.

Misdirected Claim: A claim submitted to the wrong entity for processing, e.g. a claim submitted to the wrong MCE.

	Received Claim: A claim the MCE has accepted into its inventory management system for future adjudication. For the purposes of this report, rejected claims and replacement claims are not considered received claims. **Replacement Claim:** A claim the MCE has previously adjudicated but has been resubmitted for reprocessing (i.e., adjustment). This adjustment may be due to a provider correction regarding the original submission. If a replacement claim is received, it is not considered as an original clean claim for reporting purposes. **Remittance Advice (RA) Date:** The date the MCE generates the provider remittance advice for an adjudicated claim. This is the date the provider's check or Electronic Funds Transfer (EFT) is remitted to the provider and sometimes referred to as the paid date. **Julian Date:** Represents the calendar day's number in the total days available in a calendar year (i.e., 365 days). A Julian date calculator, which converts standard calendar dates to Julian dates, can be accessed at the following website: http://www.nr.com/julian.html
Item 1	Enter the number of electronically submitted clean claims received into the MCE's claims inventory management system during the reporting quarter. This is to be separated by claim type.
Item 2	Enter the number of paper submitted clean claims received into the MCE's claims inventory management system during the reporting quarter. This is to be separated by claim type.
Item 3	This is a calculated field that sums Item 1 and Item 2 claims by claim type.
Item 4	Enter the total billed charges for each claim type for all claims received during the reporting period. This is not the amount paid by the MCE for services rendered.
Item 5	Enter the number of adjudicated clean claims that the MCE paid during the quarter, by claim type. Clean claims adjudicated during the quarter can include claims that were received during the quarter as well as those claims received in prior quarters.
Item 6	Enter the number of adjudicated clean claims that the MCE denied during the quarter, by claim type. Clean claims adjudicated during the quarter can include claims that were received during the quarter as well as those claims received in prior quarters.
Item 7	This is a calculated field that sums Item 5 and Item 6.
Item 8	This is a calculated field that is Item 5 divided by Item 7.
Item 9	This is a calculated field that is Item 6 divided by Item 7.
Item 10	This is a calculated field that is Item 7 divided by Item 3.
Item 11	Enter the total number of claims that the MCE paid with interest for all providers by claim type.

	Per IC 12-15-13 the MCE must pay interest on all clean claims paid late to providers for which the MCE is responsible. The MCE should include replacement claims in this data.
Item 12	Enter the total dollars in interest that the MCE paid to all providers by claim type.
Items 13-17	Compute for each claim type separately the number of calendar days that each clean claim received is in inventory until it is adjudicated. The formula to do this is to compute the number of calendar days between the date the MCE received the claim into the MCE's claims inventory management system and the date the MCE adjudicated the claim [finalized a claim determination/decision] in its claims system. Use Julian dates to compute the number of days for each claim. Then, distribute the total claims based on the number of days each claim was in inventory until adjudication. Enter the sum of all claims based on the number of days ranges provided: • For days in inventory 0-10 days, enter the total in Item 13. • For days in inventory 11-21 days, enter the total in Item 14. • For days in inventory 22-30 days, enter the total in Item 15. • For days in inventory 31-60 days, enter the total in Item 16. • For days in inventory greater than 60 days, enter the total in Item 17.
Item 18	This is a calculated field that sums Items 13 through 17.
Item 19	This is a validation field that checks to ensure that all claims adjudicated (Item 7) were distributed based on days in inventory (Item 18).
Item 20	This is a calculated field that computes the percentage of claims adjudicated within 21 days (sum of Items 13+14 divided by Item 18) for each claim type.
Item 21	This is a calculated field that computes the weighted average percentage of claims adjudicated within 21 days for all claim types combined (837I, 837P, 837D and pharmacy).
Item 22	This is a calculated field that computes the weighted average percentage of claims adjudicated within 21 days for all claim types combined excluding pharmacy (837I, 837P and 837D).
Item 23	This is a calculated field that computes the total claims adjudicated divided by original clean claims submitted to determine a re-adjudicated factor.Item7 divided by item 3.

Report Number	**0102**
Report Title	**Report 0102: Encounters Summary**
Purpose	To assess the MCE's timeliness in submitting adjudicated claims as encounters to OMPP.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	No
Data Reported Each Submission	For submissions April 30: Encounters Submitted in Period Jan 1 – Mar 31 For submissions July 31: Encounters Submitted in Period Apr 1 – June 30 For submissions Oct 31: Encounters Submitted in Period July 1 – Sept 30 For submissions Jan 31: Encounters Submitted in Period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	**Encounter:** A claim that was adjudicated by the MCE that contains pertinent information for submission to the FSSA Enterprise Data Warehouse (EDW). Encounters will include those claims that were paid by the MCE as well as those that were denied by the MCE. The MCE is directed to only submit adjudicated claims as encounters to the EDW. Rejected claims and unclean claims are not to be submitted. **Front-End Edits Accepted:** The MCE must submit encounters in the electronic format specified by the OMPP or its contractors. Edits are in place to determine if the file that the MCE used to submit encounters is in the format specified by the OMPP or its contractors. If it is determined that the file format is acceptable, then the front-end encounters edits are accepted. The acceptance or rejection test is completed on the contents of the entire file and not on individual encounter records. **Front-End Edits Rejected:** If it is determined that the file format submitted for encounters by the MCE to the OMPP is not acceptable, then the front-end encounters edits are rejected. The acceptance or rejection test is completed on the contents of the entire file and not on individual encounter records. In either situation, the OMPP or its contractor will send back a response file to the MCE indicating whether an encounter file was accepted or rejected on the front end.
Item 1	Enter the total dollars paid by the MCE for encounters submitted during the reporting period. This includes the point-in-time encounter submissions in the quarter, meaning that the payment amounts may reflect payments made by the MCE during the current reporting quarter as well as in prior quarters. Encounters submitted for which the MCE denied the claim will have a paid amount of $0.

Item 2	Enter the count of total claims on encounter batch files submitted that represent claims that the MCE adjudicated during the same calendar quarter that the encounter was submitted. Include in the total any encounters in which the front-end edits resulted in rejection by the OMPP.
Item 3	Enter the count of total claims on encounter batch files submitted that represent claims that the MCE adjudicated in a prior calendar quarter from the quarter in which the encounter was submitted. Include in the total any encounters in which the front-end edits resulted in rejection by the OMPP.
Item 4	This is a calculated field that sums Item 2 and Item 3.
Item 5	Enter the count of total claims on encounter batch files submitted that represent the count of total claims that the MCE paid. This includes payments made during the current quarter and any prior quarter. Include in the total any encounters in which the front-end edits resulted in rejection by the OMPP.
Item 6	Enter the count of total claims on encounter batch files submitted that represent the count of total claims that the MCE denied. This includes denials made during the current quarter and any prior quarter. Include in the total any encounters in which the front-end edits resulted in rejection by the OMPP
Item 7	This is a calculated field that sums Item 5 and Item 6.
Item 8	Enter the count of total claims on encounter batch files represented in Item 4 in which the front-end edits resulted in acceptance by the OMPP.
Item 9	Enter the count of total claims on encounter batch files represented in Item 4 in which the front-end edits resulted in rejection by the OMPP.
Item 10	Enter the count of total claims on encounter batch files represented in Item 4 in which the MCE had not yet received a notice of acceptance or rejection by the OMPP as of the last day of the reporting period. Due to timing issues, it is possible that the MCE will always include detail lines in Item 10, particularly if it is the last batch of encounters submitted at the end of the quarter.
Item 11	This is a calculated field that sums Items 8, 9 and 10.
Items 12-16	Compute for each claim type separately the number of calendar days that each claim count is in inventory from the day that the MCE adjudicates it to the day that the claim is submitted as an encounter. The formula to do this is to compute the number of calendar days between the date the MCE adjudicated the claim [finalized a claim determination/decision] in its claims system and the date that the encounter batch file was submitted (regardless of whether it was ultimately accepted or rejected by the OMPP). Use Julian dates to compute the number of days for each claim. Then, distribute the total claims based on the number of days each claim was in inventory from adjudication to encounter submission. Enter the sum of all encounters based on the number of days ranges provided: • For days in inventory 0-10 days, enter the total in Item 12.

	• For days in inventory 11-21 days, enter the total in Item 13. • For days in inventory 22-30 days, enter the total in Item 14. • For days in inventory 31-60 days, enter the total in Item 15. • For days in inventory greater than 60 days, enter the total in Item 16.
Item 17	This is a calculated field that sums Items 12 through 16.
Item 18	This is a validation field that checks to ensure that all encounters submitted (Item 7) were distributed based on days in inventory to encounter submission (Item 17).
Item 19	This is a calculated field that computes the average percentage of encounters submitted within 21 days (sum of Items 12+13 divided by Item 17) for each claim type.
Item 20	This is a calculated field that computes the weighted average percentage of encounters submitted within 21 days for all claim types combined (837I, 837P, 837D and pharmacy).

Report Number	**0103**
Report Title	**Report 0103: Claims Denial Reasons**
Purpose	To assess the MCE's adjudicated clean claims denial reasons and determine if common reasons for claims denials could indicate opportunities for improving claims submissions through additional provider education and outreach.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	No
Data Reported Each Submission	For submissions April 30: Claims Adjudicated in Period Jan 1 – Mar 31 For submissions July 31: Claims Adjudicated in Period Apr 1 – June 30 For submissions Oct 31: Claims Adjudicated in Period July 1 – Sept 30 For submissions Jan 31: Claims Adjudicated in Period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	This report is conditional based on the results determined on Report 0101 for the quarter. MCEs are only required to report when the denial rate for a specific claim type in a specific line of business exceeds 15.0% in the most recent quarter. Complete only the section(s) of the report applicable to the specific claim type and line of business in which the denial rate exceeds 15.0%. Do not compute a weighted average denial rate. For example, do not compute a denial rate for all HHW claims across all claim types. Nor should you compute an overall denial rate for 837I claims across lines of business. Compute a separate denial rate for 837I for HHW, HIP and HCC. If the conditions are met when the MCE must submit denial reasons, the MCE should first indicate on the top line of the appropriate section of the report the total denials for the claim type for all reasons including those outside the top 20 reasons. Then, the MCE should report the top 20 denial reasons (in descending order based on volume) within this claim type and line of business. Report the following: • The MCE denial reason code • A brief description of the denial reason • The count of occurrences for this denial reason in this claim type and line of business

	The Percent column will automatically compute the claims denied for each denial reason as a percentage of all claims denied. Since claims can be denied for multiple reasons, the sum of the percentages may be greater than 100%.

Report Number	**0104**
Report Title	**Report 0104: Paid Abortion Claims Summary**
Purpose	To track all paid abortion claims for the reported quarter for OMPP to identify the appropriate source of funding for each claim.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	No
Data Reported Each Submission	For submissions April 30: Claims Adjudicated in Period Jan 1 – Mar 31 For submissions July 31: Claims Adjudicated in Period Apr 1 – June 30 For submissions Oct 31: Claims Adjudicated in Period July 1 – Sept 30 For submissions Jan 31: Claims Adjudicated in Period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	List all abortion claims that were paid during the quarter based upon one of the four (4) listed categories of elective abortions. All other abortion claims should be denied payment. The supporting medical documentation must also be submitted and posted to the SharePoint site used for all other report submissions. Supporting medical documentation must be separately submitted in a PDF file for each claim included in the report. **This report must be submitted even if no abortion claims were paid during the reporting quarter and should contain documentation that no abortion claims were paid.**
Column A	Enter the original claim number; DO NOT indicate the claim attachment number.
Column B	Select from the drop-down list the program that this member belongs to.
Column C	Enter the HCPCS Procedure Code on the claim, if applicable.
Column D	Enter the ICD-10 Diagnosis Code on the claim.
Column E	Enter the ICD-10 Procedure Code on the claim, if applicable.
Column F	Enter the NPI number on the claim.
Column G	Select from the following the categories the claim falls into: • Rape • Incest • Necessary to save the life of the mother; or, • Necessary to avoid serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman
Column H	Enter the file name of the PDF file for the supporting medical documentation for each claim.

Report Number	**0201**
Report Title	**Report 0201: Member Helpline Performance**
Purpose	To monitor the MCE's availability to provide service to its members calling the Member Helpline.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lag?	Not applicable
Data Reported Each Submission	For submissions April 30: Calls Received in Period Jan 1 – Mar 31 For submissions July 31: Calls Received in Period Apr 1 – June 30 For submissions Oct 31: Calls Received in Period July 1 – Sept 30 For submissions Jan 31: Calls Received in Period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Performance Measures	The MCE must maintain quarterly telephone service for the member services helplines. Requirements are: • A service efficiency of at least 85% of calls received answered by a live voice within 30 seconds of being routed through the call center menu • Less than 5% of the calls received in the Member Helpline remaining unanswered (abandonment rate). • 100% of all of all after hour calls must be returned or attempted to be returned within one (1) business day • 100% of all electronic inquiries (email and member website) must be returned or attempted to be returned within one (1) business day • 85% of all calls to the Member Helpline must be resolved during the initial call
Item 1	Enter the total number of member calls received by the Member Helpline during hours of operation. This includes: • Calls in which the member calls directly into the Member Helpline • Transfers into the Member Helpline • The member selects an option placing the member into the automatic call distribution (ACD) call queue. This does not apply to other external call centers (e.g., pharmacy).
Item 2	Enter the total number of member calls answered on the Member Helpline the in the reporting period. This number should not be greater than the number of calls received and should include the number of calls answered within 30 seconds by a live voice.

Item 3	Enter the number of member calls answered within 30 seconds by a live voice on the Member Helpline in the reporting period. This number should not be greater than the number of calls received.
Item 4	This is a calculated field. Item 3 divided by Item 1.
Item 5	This is a validation field. It measures whether, over the course of the entire quarter, the MCE met the performance metric for percent of calls answered within 30 seconds.
Item 6	Identify the number of calls received into the Member Helpline during hours of operation that were abandoned (disconnected) by the caller or the system before being answered.
Item 7	This is a calculated field. Item 6 divided by Item 1.
Item 8	This is a validation field. It measures whether, over the course of the entire quarter, the MCE met the performance metric for an abandonment rate of under 5%.
Item 9	This is a validation field. It measures whether the sum of calls answered and abandoned equals the total calls received.
Item 10	Enter the number of member calls resolved during the initial call. Resolved means either that all questions were answered or that there was no need for additional follow-up with the member.
Item 11	This is a calculated field. Item 10 divided by Item 2.
Item 12	This is a validation field. It measures whether, over the course of the entire quarter, the MCE met the performance metric for percent of calls resolved during the initial call.
Item 13	Enter the number of member calls received after business hours on the after-hours voice messaging system for the Member Helpline.
Item 14	Enter the number of member calls received in Item 13 in which the MCE returned (or attempted to return) within the next business day after receipt. To be considered an attempted call back, the original call must be from a legitimate caller, excluding telemarketing calls and have identifying information (name and number). Hang up calls can be excluded.
Item 15	This is a calculated field. Item 14 divided by Item 13.
Item 16	This is a validation field. It measures whether, over the course of the entire quarter, the MCE met the performance metric for percent of calls returned (or attempted to return) within the next business day after receipt.
Item 17	Enter the number of electronic inquiries received after hours. Include email and member website inquiries.
Item 18	Enter the number of member electronic inquiries received in Item 17 in which the MCE returned (or attempted to return) within the next business day after receipt.
Item 19	This is a calculated field. Item 18 divided by Item 17.
Item 20	This is a validation field. It measures whether, over the course of the entire quarter, the MCE met the performance metric for percent of electronic inquiries returned (or attempted to return) within the next business day after receipt.

Report Number	**0202**
Report Title	**Report 0202: Member Grievances and Appeals**
Purpose	To monitor the volume and timely resolution of the MCE's member grievances and appeals.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lag?	Not applicable
Data Reported Each Submission	For submissions April 30: Grievances and Appeals Received or Resolved in Period Jan 1 – Mar 31 For submissions July 31: Grievances and Appeals Received or Resolved in Period Apr 1 – June 30 For submissions Oct 31: Grievances and Appeals Received or Resolved in Period July 1 – Sept 30 For submissions Jan 31: Grievances and Appeals Received or Resolved in Period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Definitions	**Resolved** The term "resolved" means that an answer or solution has been found regarding the member's grievance; therefore, no further action is needed. **Grievances** A grievance is defined as an expression of dissatisfaction about any matter other than an "action." Therefore, a grievance does not include any of the following matters: • The denial or limited authorization of a requested service, including the type or level of service • The reduction, suspension or termination of a previously authorized service • The denial, in whole or in part, of payment for a service • The failure to provide services in a timely manner • The failure to act within the required timeframe • The failure to allow a resident of a rural area, with access to only one MCE, to obtain services outside the network Any other matters that pertain to the delivery of health care, such as dissatisfaction with the quality of care or services received, provider or provider staff conduct (such as rudeness) or the failure to respect an enrollee's rights **should** be counted as a grievance regardless of the timeframe for resolution. If the matter requires that the MCE review the situation and supply a decision, the grievance should include appeal rights if the subsequent decision is an adverse determination.

	Example Scenario: Member Doe calls on a Monday to report that her home health aide is inattentive and providing poor service. Member believes that the plan should intervene to correct this behavior. *Possible Outcome:* The health plan documents the contact. The customer service representative (CSR) reports the contact to the Network department to review other customer survey results and member or health plan staff concerns related to this provider. This health plan decides a site survey is warranted and completes the survey on Thursday of the same week. A letter is mailed to the member documenting the action taken by the health plan. An adverse decision is not made, therefore appeal language is not included. This grievance is counted on the report. A member may file a grievance orally or in writing and should be included in the reporting count regardless of how the grievance was initiated. A member may request an expedited grievance in any instance in which the matter may seriously jeopardize the life or health of the member or the member's ability to reach and maintain maximum function. Expedited grievances should be included in this count. **Appeals** The Member Appeal report includes any appeal that is a result of any of the following "actions" as bulleted below: • The denial or limited authorization of a requested service, including the type or level of service • The reduction, suspension or termination of a previously authorized service • The denial, in whole or in part, of payment for a service • The failure to provide services in a timely manner • The failure to act within the required timeframe • The failure to allow a resident of a rural area, with access to only one MCE, to obtain services outside the network It further includes any appeal resulting from an adverse decision of a grievance. These appeals may be filed by the member or the provider on the behalf of a member. Example Scenario:

	Member Smith calls to inquire why she received a discontinuance/denial notice for further home health services. *Expected Outcome:* Upon pulling up the concurrent review decision, the customer service representative (CSR) reiterates the denial rationale as described on the denial letter. The CSR reiterates the appeal language that is included on the denial notice and asks Member Smith if she would like to file an appeal orally. The MCE documents the contact and takes all applicable information. The CSR informs the member that the appeal is filed but will also mail her the appeal for her signature to confirm her wish to pursue the appeal for continued services. This appeal is counted in the report. The Member Appeal report does not include claim payment disputes. This report only includes appeals reconsidered by the MCE or its sub-delegated entity and not those appealed to an Independent External Review (IER) or FSSA hearing.
Performance Measures	The MCE should resolve all member grievances within 30 calendar days of receipt. The MCE should resolve standard member appeals within 30 calendar days of receipt. (For example: Grievance receipt 3/1. Resolution Due 3/31). The MCE should resolve expedited appeals within 48 hours of receipt.
Items 1, 16, 37	These are calculated fields that sum the data from the rows below it to obtain total grievances for each line of business.
Items 6, 23, 42	These are calculated fields that sum the data from the rows below it to obtain total expedited appeals for each line of business.
Items 11, 30, 47	These are calculated fields that sum the data from the rows below it to obtain total non-expedited appeals for each line of business.
Items 2, 17, 38	Among the total grievances reported, enter the total grievances that the MCE categorized as related to pharmacy services or providers. Examples may include, but are not limited to, members not being able to obtain a script, inability to access a pharmacy when needed, or pharmacists that did not properly communicate when or how often to take a prescription when asked.
Items 3, 18, 39	Among the total grievances reported, enter the total grievances that the MCE categorized as related to substance use disorder (SUD) services or providers. Examples may include, but are not limited to, members being turned away from treatment, no provider or facility nearby to offer assistance, or facility/provider rudeness to the member.
Items 4, 19, 40	Among the total grievances reported by or on behalf of members, enter the total grievances that the MCE categorized as related to serious mental illness (SMI) or serious emotional disturbance (SED)

	services or providers. Count each grievance once, regardless of whether more than one grievance is filed by the same member. Examples may include, but are not limited to, members being turned away from treatment, no provider or facility nearby to offer assistance, or facility/provider rudeness to the member.
Item 20	Among the total grievances reported, enter the total grievances that the MCE categorized in HIP that relate to quality of care if not already classified in Items 17, 18, or 19.
Item21	Among the total grievances reported, enter the total grievances that the MCE categorized in HIP that relate to a provider or the MCE not already classified in Items 17, 18, 19, or 20.
Items 5, 22, 41	Among the total grievances reported, enter the total grievances that the MCE received but not already categorized in Items 2, 3, or 4 for HHW, Items 17, 18, 19, 20, or 21 for HIP, or Items 38, 39, or 40 for HCC.
Items 7, 24, 43	Among the total expedited appeals reported, enter the total expedited appeals that the MCE categorized as related to pharmacy services and providers. Apply the same categorization criteria used in Items 2, 17 and 38 to classify pharmacy grievances.
Items 8, 25, 44	Among the total expedited appeals reported, enter the total expedited appeals that the MCE categorized as related to SUD services and providers. Apply the same categorization criteria used in Items 3, 18 and 39 to classify SUD grievances.
Items 9, 26, 45	Among the total expedited appeals reported by or on behalf of members, enter the total expedited appeals that the MCE categorized as related to SMI or SED services and providers. Count each expedited appeal once, regardless of whether more than one appeal is filed by the same member. Appeals that are processed through multiple levels of review should only be counted once. Apply the same categorization criteria used in Items 4, 19 and 40 to classify SMI/SED grievances.
Item 27	Among the total expedited appeals reported, enter the total that the MCE categorized in HIP that relate to eligibility and POWER Accounts.
Item 28	Among the total expedited appeals reported, enter the total that the MCE categorized in HIP that relate to denial of benefits not already classified in Items 24-27.
Items 10, 29, 46	Among the total expedited appeals reported, enter the total that the MCE received but not already categorized in Items 7, 8, or 9 for HHW, Items 24, 25, 26, 27, or 28 for HIP, or Items 43, 44, or 45 for HCC.
Items 12, 31, 48	Among the total non-expedited appeals reported, enter the total non-expedited appeals that the MCE categorized as related to pharmacy services and providers. Apply the same categorization criteria used in Items 2, 17 and 38 to classify pharmacy grievances.
Items 13, 32, 49	Among the total non-expedited appeals reported, enter the total non-expedited appeals that the MCE categorized as related to SUD services and providers. Apply the same categorization criteria used in Items 3, 18 and 39 to classify SUD grievances.

Items 14, 33, 50	Among the total non-expedited appeals reported by or on behalf of members, enter the total non-expedited appeals that the MCE categorized as related to SMI or SED services and providers. Count each non-expedited appeal once, regardless of whether more than one appeal is filed by the same member. Appeals that are processed through multiple levels of review should only be counted once. Apply the same categorization criteria used in Items 4, 19, and 40 to classify SMI/SED grievances.
Item 34	Among the total non-expedited appeals reported, enter the total that the MCE categorized in HIP that relate to eligibility and POWER Accounts. Apply the same categorization criteria used in Item 27 to classify expedited appeals.
Item 35	Among the total non-expedited appeals reported, enter the total that the MCE categorized in HIP that relate to denial of benefits. Apply the same categorization criteria used in Item 28 to classify expedited appeals.
Items 15, 36, 51	Among the total non-expedited appeals reported, enter the total that the MCE received but not already categorized in Items 12, 13, or 14 for HHW, Items 31, 32, 33, 34, or 35 for HIP, or Items 48, 49, or 50 for HCC.
Column C	For each item, report the count of grievances, expedited appeals, or non-expedited appeals that were received in the current quarter regardless of their resolution status.
Columns D and E	For each item, split the count of grievances, expedited appeals, or non-expedited appeals between those that were both received and resolved in the current quarter (Column D) and those that were received in a prior quarter but resolved in the current quarter (Column E).
Columns F and G	For each item, split the count of grievances and non-expedited appeals between those that were resolved within 30 calendar days after received (Column F) and those that were resolved in excess of 30 calendar days after received (Column G).
Columns H and I	For each item, split the count of expedited appeals between those that were resolved within 48 hours after received (Column H) and those that were resolved in excess of 48 hours after received (Column I).
Column J	This column contains validations to ensure that the sum of the values in Columns D and E equals either the sum of the values in Columns F and G or the sum in Columns H and I.

Report Number	**0203**
Report Title	**Report 0203: Independent External Reviews (IERs) & FSSA Hearings**
Purpose	To monitor the number and timely resolution of member and provider requests for Independent External Reviews (IERs) or FSSA hearings during the reporting period.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lag?	Not applicable
Data Reported Each Submission	For submissions April 30: IERs and FSSA Hearings Received or Resolved in Period Jan 1 – Mar 31 For submissions July 31: IERs and FSSA Hearings Received or Resolved in Period Apr 1 – June 30 For submissions Oct 31: IERs and FSSA Hearings Received or Resolved in Period July 1 – Sept 30 For submissions Jan 31: IERs and FSSA Hearings Received or Resolved in Period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Definitions	The resolution date is considered to be either: • For IERs, the date that the IER gives its decision to the MCE; or • For FSSA hearings, the date that the FSSA informs the member or the provider of the resolution decision (i.e., the date FSSA mailed the resolution notice to the member/provider or the date FSSA verbally notified the member and the FSSA documented that notification date in its member appeal files). FSSA State Fair Hearings include any matter that has been subsequently appealed after receipt of an MCE or sub-delegated entity level appeal decision.
Items 1, 9, 19	These are calculated fields that sum the data from the rows below it to obtain total IERs for each line of business.
Items 5, 13, 23	These are calculated fields that sum the data from the rows below it to obtain total FSSA hearings for each line of business.
Items 2, 10, 20	Among the total IERs reported, enter the total IERs that the MCE categorized as related to substance use disorder (SUD) services or providers. Examples may include, but are not limited to, members being turned away from treatment, authorization denied for SUD services, no provider or facility nearby to offer assistance, or facility/provider rudeness to the member.
Items 3, 11, 21	Among the total IERs reported, enter the total IERs that the MCE categorized as related to prior authorization denial except for those authorization denials for SUD services already captured in Items 2, 10 or 20.
Items 4, 12, 22	Among the total IERs reported, enter the IERs that the MCE received but not already categorized in Items 2 or 3 for HHW, Items 10 or 11 for HIP, or Items 20 or 21 for HCC.

Item 14	Among the total FSSA hearings reported, enter the total that the MCE categorized in HIP that relate to POWER Accounts.
Item 15	Among the total FSSA hearings reported, enter the total that the MCE categorized in HIP that relate to Medically Frail determinations.
Items 6, 16, 24	Among the total FSSA hearings reported, enter the total hearings that the MCE categorized as related to SUD services and providers. Apply the same categorization criteria used in Items 2, 10 and 20 to classify SUD IERs.
Items 7, 17, 25	Among the total FSSA hearings reported, enter the total hearings that the MCE categorized as related to prior authorization denials. Apply the same categorization criteria used in Items 3, 11 and 21 to classify prior authorization denial IERs.
Items 8, 18, 26	Among the total FSSA hearings reported, enter the total hearings that the MCE received but not already categorized in Items 6 or 7 for HHW, Items 14, 15, 16 or 17 for HIP, or Items 24 or 25 for HCC.
Column C	For each item, report the number of requests for FSSA hearings received in the quarter regardless of the resolution status.
Columns D and E	For each item, split the IERs and FSSA hearings between those that were both received and resolved in the current quarter (Column D) and those that were received in a prior quarter but resolved in the current quarter (Column E).
Columns F, G, H and I	For each item, split the IERs and FSSA hearings between those that were rendered partially or fully in favor of the member (Column F), those that were in favor of the provider (Column G), those rendered in favor of the MCE (Column H), and those where the hearing was retracted prior to final decision (Column I).
Column J	This column contains validations to ensure that the sum of the values in Columns D and E equals the sum of the values in Columns F, G, H and I.

Report Number	**0204**
Report Title	**Report 0204: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Summary**
Purpose	To assess and document the experiences members report with their managed care organization as an indicator of quality of various aspects of care and customer service.
Format	NCQA-certified survey vendor format
Periodicity of Submission	Annually
Lag?	Not applicable
Data Reported Each Submission	Report due July 31 of each year based on findings from members in the previous calendar year
Lines of Business to Report	HHW, HIP and HCC
Definitions	Each MCE must meet the minimum response total of 411 responses to ensure the representative scores are accurate and statistically valid. Over-sampling and monitoring prior year response rates are recommended to meet this minimum.
Submission	MCEs must use an NCQA-certified vendor to conduct the CAHPS survey. The MCE can find additional information about this survey, survey tool and NCQA's nationally standardized reporting methodology on the NCQA website at: http://www.ncqa.org.

Report Number	**0205**
Report Title	**Report 0205: Enhanced Services Program**
Purpose	To assess and document the MCEs enhanced service program requests.
Format	OMPP Excel Template
Periodicity of Submission	Annually, Ad hoc
Data Reported Each Submission	January 31
Lines of Business to Report	HHW, HIP and HCC
Qualifications/Definitions	This is an annual and ad-hoc report. In addition to the annual submission January 31, the enhanced benefit log is also due on an Ad Hoc basis. The MCE must submit an updated Enhanced Benefit log within 5 business days upon approval with each new enhanced benefit submission. The log must be updated (highlighted) with all new or modified information regarding all existing enhanced benefits. Enhanced services may include, but are not limited to, items such as: • Incentives for obtaining preventive services; • Enhanced tobacco treatment dependence services; • Disease management programs or incentives beyond those required by the State; • Healthy lifestyles incentives; and • Group visits with nurse educators and other patients. • Enhanced transportation arrangements (i.e. transportation to obtain pharmacy services, attend member education workshops on nutrition, healthy living, parenting, prenatal classes, etc.); • Medical equipment or devices to assist in prevention, wellness, or management of chronic conditions; and • Cost effective supplemental services which can provide services in a less restrictive setting.
Column A	Enter the name of the enhanced Service Program submitted by the MCE.
Column B	Enter the name of the Medicaid Program the Enhanced Service will be provided for. Enter the abbreviation for the Medicaid Program Name(s) or enter "All" if for all programs.
Column C	Select yes or no from the drop-down to indicate whether this enhanced service is still active. **If MCE selects No from the drop-down, indicating the program is no longer active, complete the Discontinued Enhanced Benefits Tab.**
Column D	Enter the date the MCE submitted the Enhanced Service for review and approval.

Column E	Select the outcome status of the review as to whether this enhanced service was approved or not.
Column F	Enter the date OMPP Contract Compliance approved or did not approve (concluded) the enhanced service.
Column G	Enter the goal the MCE is trying to achieve. Copy the text from the Review and Approval Form.
Column H	Enter the scheduled start date and end date.
Column I	Enter the target population. Who is benefiting from the services?
Column J	What geographic area is the service offered? Identify the geographical area(s) being targeted. Indicate specific region(s), specific counties or where the enhanced benefit is a state-wide initiative.
Column K	Select yes or no for whether incentives will be offered as part of this enhanced service.
Column L	Describe incentives that will be given. Place N/A if there will be no incentives.
Column M	Enter the value per item and total value of the proposed items member may receive in a year (Dollar amount).
Column N	Enter Date the MCE internal assessment occurred.
Column O	Document if the program has achieved the established goal(s), if the program is close to achieving the goals, or if the program is far from achieving the established goal (document narrative).
Column P	Indicate with a Yes or No if the program will achieve the goal(s) within the timeline established during the approval process.
Column Q	Document the impact the program has had on the MCE members that have been engaged (document narrative).
Column R	Document the impact the program has had on the MCE provider network (document narrative).
Column S	Document the impact the program has had on the community for the geographic area the enhanced service is conducted (document narrative).
Column T	Enter the total number of members engaged in the program/utilized the service in the calendar year (January - December).
Column U	Indicate Yes or No if the program is necessary when members are not enrolled in the program in the current year. Conduct a needs assessment and utilization review if there is no member participation. **If MCE decides to discontinue the EB due to lack of participation, complete the discontinued benefits tab.**
Column V	Enter the total number of dollars spent on the service and/or incentive in the calendar year (January - December).

Column W	Document the improvement the MCE has experienced in HEDIS rates and/or member behaviors since the implementation of the program (document narrative).
Column X	Enter the race and ethnicity totals of the participants for each program
Column Y	Enter any additional notes regarding the program.

Report Number	**0206**
Report Title	**Report 0206: Annual Member Grievances and Appeals**
Purpose	To monitor the volume and timely resolution of the MCE's member grievances and appeals.
Format	OMPP Excel template
Periodicity of Submission	Annually
Lag?	Not applicable
Data Reported Each Submission	HIP/HHW: April 30 HCC: July 31
Lines of Business to Report	HHW, HIP and HCC
Definitions	**Resolved** The term "resolved" means that an answer or solution has been found regarding the member's grievance; therefore, no further action is needed. **Grievances** A grievance is defined as an expression of dissatisfaction about any matter other than an "action." Therefore, a grievance does not include any of the following matters: • The denial or limited authorization of a requested service, including the type or level of service • The reduction, suspension or termination of a previously authorized service • The denial, in whole or in part, of payment for a service • The failure to provide services in a timely manner • The failure to act within the required timeframe • The failure to allow a resident of a rural area, with access to only one MCE, to obtain services outside the network Any other matters that pertain to the delivery of health care, such as dissatisfaction with the quality of care or services received, provider or provider staff conduct (such as rudeness) or the failure to respect an enrollee's rights **should** be counted as a grievance regardless of the timeframe for resolution. If the matter requires that the MCE review the situation and supply a decision, the grievance should include appeal rights if the subsequent decision is an adverse determination.

	Example Scenario: Member Doe calls on a Monday to report that her home health aide is inattentive and providing poor service. Member believes that the plan should intervene to correct this behavior. *Possible Outcome:* The health plan documents the contact. The customer service representative (CSR) reports the contact to the Network department to review other customer survey results and member or health plan staff concerns related to this provider. This health plan decides a site survey is warranted and completes the survey on Thursday of the same week. A letter is mailed to the member documenting the action taken by the health plan. An adverse decision is not made, therefore appeal language is not included. This grievance is counted on the report. A member may file a grievance orally or in writing and should be included in the reporting count regardless of how the grievance was initiated. A member may request an expedited grievance in any instance in which the matter may seriously jeopardize the life or health of the member or the member's ability to reach and maintain maximum function. Expedited grievances should be included in this count. **Appeals** The Member Appeal report includes any appeal that is a result of any of the following "actions" as bulleted below: • The denial or limited authorization of a requested service, including the type or level of service • The reduction, suspension or termination of a previously authorized service • The denial, in whole or in part, of payment for a service • The failure to provide services in a timely manner • The failure to act within the required timeframe • The failure to allow a resident of a rural area, with access to only one MCE, to obtain services outside the network It further includes any appeal resulting from an adverse decision of a grievance. These appeals may be filed by the member or the provider on the behalf of a member. Example Scenario: Member Smith calls to inquire why she received a discontinuance/denial notice for further home health services.

	Expected Outcome: Upon pulling up the concurrent review decision, the customer service representative (CSR) reiterates the denial rationale as described on the denial letter. The CSR reiterates the appeal language that is included on the denial notice and asks Member Smith if she would like to file an appeal orally. The MCE documents the contact and takes all applicable information. The CSR informs the member that the appeal is filed but will also mail her the appeal for her signature to confirm her wish to pursue the appeal for continued services. This appeal is counted in the report. The Member Appeal report does not include claim payment disputes. This report only includes appeals reconsidered by the MCE or its sub-delegated entity and not those appealed to an Independent External Review (IER) or FSSA hearing. **LTSS User** An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed).
Performance Measures	The MCE should resolve all member grievances within 30 calendar days of receipt. The MCE should resolve standard member appeals within 30 calendar days of receipt. The MCE should resolve expedited appeals within 48 hours of receipt.
Specifications Used to Guide Definition	The reporting year for each program is defined by the MCE's contract year for that program. For HIP, the reporting year should be the last completed calendar year. For HHW, the reporting year should be the last completed calendar year. For HCC, the reporting year should be the last completed 12-month period from April-March.
Item 1	Enter the total numbers of grievances resolved during the reporting year. Enter the total numbers of appeals resolved during the reporting year as of the first day of the last month of the reporting year. For HIP and HHW, this is the total number of appeals resolved between January 1st of the reporting year and December 1st of the reporting year. For HCC, this is the total number of appeals resolved between April 1st of the reporting year and March 1st of the reporting year.

Item 2	Enter the total numbers of appeals and grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year. For HIP and HHW, this is as of December 1st of the reporting year. For HCC, this is as of March 1st of the reporting year.
Item 3	Enter the total numbers of appeals and grievances filed during the reporting year by or on behalf of LTSS users. If not applicable, write "N/A." An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).
Item 4	Among the total grievances reported, enter the total number of grievances that were timely resolved by the MCE.
Item 5	Among the total standard appeals resolved during the reporting year, enter the total number of standard appeals that were timely resolved by the MCE.
Item 6	Among the total expedited appeals resolved during the reporting year, enter the total number of expedited appeals that were timely resolved by the MCE.
Item 7	Among the totals of appeals and grievances reported, enter the total numbers of appeals and grievances that the MCE categorized as related to general inpatient care, including diagnostic and laboratory services. Do not include appeals and grievances related to inpatient behavioral health services – those should be included in Item 9.
Item 8	Among the totals of appeals and grievances reported, enter the total numbers of appeals and grievances that the MCE categorized as related to general outpatient care, including diagnostic and laboratory services. Do not include appeals and grievances related to outpatient behavioral health services – those should be included in Item 10.
Item 9	Among the totals of appeals and grievances reported, enter the total numbers of appeals and grievances that the MCE categorized as related to inpatient mental health and/or substance use services.
Item 10	Among the totals of appeals and grievances reported, enter the total numbers of appeals and grievances that the MCE categorized as related to outpatient mental health and/or substance use services.
Item 11	Among the totals of appeals and grievances reported, enter the total numbers of appeals and grievances that the MCE categorized as related to the managed care plan coverage of outpatient prescription drugs.
Item 12	Among the totals of appeals and grievances reported, enter the total numbers of appeals and grievances that the MCE categorized as related to skilled nursing facility (SNF) services.
Item 13	Among the totals of appeals and grievances reported, enter the total number of appeals and grievances related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".

Item 14	Among the totals of appeals and grievances reported, enter the total number of appeals and grievances related to dental services.
Item 15	Among the totals of appeals and grievances reported, enter the total numbers of appeals and grievances related to non-emergency medical transportation (NEMT).
Item 16	Among the totals of appeals and grievances reported, enter the total numbers of appeals and grievances related to other service types not reported in Items 7-15.
Item 17	Among the total grievances reported, enter the total number of grievances related to related to plan or provider customer service. Customer service grievances include complaints about interactions with the MCE's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.
Item 18	Among the total grievances reported, enter the total number of grievances related to MCE or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.
Item 19	Among the total grievances reported, enter the total number of grievances related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.
Item 20	Among the total grievances reported, enter the total number of grievances related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.
Item 21	Among the total grievances reported, enter the total number of grievances related to MCE communications. MCE communication grievances include grievances related to the clarity or accuracy of enrollee materials or other MCE communications or to an enrollee's access to or the accessibility of enrollee materials or MCE communications.
Item 22	Among the total grievances reported, enter the total number of grievances that were filed for a reason related to payment or billing issues.
Item 23	Among the total grievances reported, enter the total number of grievances related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the MCE, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.
Item 24	Among the total grievances reported, enter the total number of grievances related to abuse, neglect, or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.

Item 25	Among the total grievances, enter the total number of grievances that were filed due to a lack of timely MCE response to a service authorization or appeal request (including requests to expedite or extend appeals).
Item 26	Among the total grievances, enter the total number of grievances that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.
Item 27	Among the total grievances reported, enter the total number of grievances related to reasons other than those reported in Items 18-27.
Item 28	Among the total appeals reported, enter the total number of appeals that the MCE categorized as related to the MCE's denial of authorization for a service not yet rendered or limited authorization of a service. Appeals related to denial of payment for a service already rendered should be counted in Item 32.
Item 29	Among the total appeals reported, enter the total number of appeals that the MCE categorized as related to the MCE's reduction, suspension, or termination of a previously authorized service.
Item 30	Among the total appeals reported, enter the total number of appeals that the MCE categorized as related to the MCE's denial, in whole or in part, of payment for a service that was already rendered.
Item 31	Among the total appeals reported, enter the total number of appeals that the MCE categorized as related to the MCE's failure to provide services in a timely manner.
Item 32	Among the total appeals reported, enter the total number of appeals that the MCE categorized as related to the MCE's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
Item 33	Among the total appeals reported, enter the total number of appeals that the MCE categorized as related to the MCE's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).
Item 34	Among the total appeals reported, enter the total number of appeals that the MCE categorized as related to the MCE's denial of an enrollee's request to dispute a financial liability.
Columns C, E, G	These columns should only contain counts of grievances.
Columns D, F, H	These columns should only contain counts of appeals.

Report Number	**0301**
Report Title	**Report 0301: Provider Helpline Performance (excluding Pharmacy)**
Purpose	To monitor the MCE's availability to provide service to its providers calling the Provider Helpline.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Not applicable
Data Reported Each Submission	For submissions April 30: Calls Received in Period Jan 1 – Mar 31 For submissions July 31: Calls Received in Period Apr 1 – June 30 For submissions Oct 31: Calls Received in Period July 1 – Sept 30 For submissions Jan 31: Calls Received in Period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Performance Measures	The MCE must maintain average monthly telephone service for the provider services helpline. Requirements: • Service efficiency at 85 percent of calls received being answered by a live voice within 30 seconds; and • Less than 5 percent of the calls received in the Provider Helpline remaining unanswered (abandoned).
Item 1	Enter the total number of provider calls received by the MCE to the Provider Helpline automated call distribution (ACD) call queue during open hours of operation, including calls in which the provider

	calls directly into the Provider Helpline, transfers into the Provider Helpline or selects a provider services option placing the provider into the call queue.
Item 2	Enter the number of provider calls answered on the Provider Helpline ACD call queue in the reporting period. This number should not be greater than the number of calls received and should include the number of calls answered within 30 seconds by a live voice.
Item 3	Enter the number of provider calls answered within 30 seconds by a live voice on the Provider Helpline in the reporting period. This number should not be greater than the number of calls received.
Item 4	This is a calculated field. Item 3 divided by Item 1.
Item 5	This is a validation field. It measures whether, over the course of the entire quarter, the MCE met the performance metric for percent of calls answered within 30 seconds.
Item 6	Enter the number of calls received into the Provider Helpline during open hours of operation that were abandoned (disconnected) by the caller or the system before being answered.
Item 7	This is a calculated field. Item 6 divided by Item 1.
Item 8	This is a validation field. It measures whether, over the course of the entire quarter, the MCE met the performance metric for an abandonment rate of under 5%.
Item 9	This is a validation field. It measures whether the sum of calls answered and abandoned equals the total calls received.
Item 10	Enter the number of provider calls received after business hours on the after-hours voice messaging system for the Provider Helpline.
Item 11	Enter the number of provider calls received in Item 10 in which the MCE returned (or attempted to return) within the next business day after receipt. To be considered an attempted call back, the original call must be from a legitimate caller, excluding telemarketing calls and have identifying information (name and number). Hang up calls can be excluded.
Item 12	This is a calculated field. Item 11 divided by Item 10.

Report Number	**0302**
Report Title	**Report 0302: Provider Helpline Performance (Pharmacy only)**
Purpose	To monitor the MCE's contracted pharmacy benefit manager's or independent pharmacy call center's availability to provide service to those calling the Provider Helpline.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Not applicable
Data Reported Each Submission	For submissions April 30: Calls Received in Period Jan 1 – Mar 31 For submissions July 31: Calls Received in Period Apr 1 – June 30 For submissions Oct 31: Calls Received in Period July 1 – Sept 30 For submissions Jan 31: Calls Received in Period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Performance Measures	The MCE must maintain average monthly telephone service for the pharmacy services helpline. Requirements: • Service efficiency at 85 percent of calls received being answered by a live voice within 30 seconds; and • Less than 5 percent of the calls received in the Provider Helpline remaining unanswered (abandoned).
Item 1	Enter the total number of provider calls received by the MCE to the Pharmacy Helpline call queue during open hours of operation, including calls in which the provider calls directly into the Pharmacy Helpline, transfers into the Pharmacy Helpline or selects a provider services option placing the provider into the call queue.
Item 2	Enter the number of provider calls answered on the Pharmacy Helpline call queue in the reporting period. This number should not be greater than the number of calls received and should include the number of calls answered within 30 seconds by a live voice.
Item 3	Enter the number of provider calls answered within 30 seconds by a live voice on the Pharmacy Helpline in the reporting period. This number should not be greater than the number of calls received.
Item 4	This is a calculated field. Item 3 divided by Item 1.
Item 5	This is a validation field. It measures whether, over the course of the entire quarter, the MCE met the performance metric for percent of calls answered within 30 seconds.
Item 6	Enter the number of calls received into the Pharmacy Helpline during open hours of operation that were abandoned (disconnected) by the caller or the system before being answered.
Item 7	This is a calculated field. Item 6 divided by Item 1.

Item 8	This is a validation field. It measures whether, over the course of the entire quarter, the MCE met the performance metric for an abandonment rate of under 5%.
Item 9	This is a validation field. It measures whether the sum of calls answered and abandoned equals the total calls received.
Item 10	Enter the number of provider calls received after business hours on the after-hours voice messaging system for the Pharmacy Helpline.
Item 11	Enter the number of provider calls received in Item 10 in which the MCE returned (or attempted to return) within the next business day after receipt. . To be considered an attempted call back, the original call must be from a legitimate caller, excluding telemarketing calls and have identifying information (name and number). Hang up calls can be excluded.
Item 12	This is a calculated field. Item 11 divided by Item 10.

Report Number	**0303**
Report Title	**Report 0303: Provider Claim Disputes**
Purpose	To monitor the volume of MCE provider claim disputes received from all providers. **Provider objections and formal appeals involving pharmacy issues are not included in this report.**
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Not applicable
Data Reported Each Submission	For submissions April 30: Claim Disputes Received or Resolved in Period Jan 1 – Mar 31 For submissions July 31: Claim Disputes Received or Resolved in Period Apr 1 – June 30 For submissions Oct 31: Claim Disputes Received or Resolved in Period July 1 – Sept 30 For submissions Jan 31: Claim Disputes Received or Resolved in Period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Definitions	This report must be submitted by the MCE for those provider disputes received from all providers (i.e., in-network and out-of-network). A dispute may be informal or formal to be captured in this report. A provider may initiate an informal dispute verbally, but it must be followed up in writing for the process to take place. **Informal Dispute:** A provider's written objection to a determination (or failure to make a determination) by the MCE involving the provider's claim. **Formal Dispute:** A provider's written request to appeal the MCE's decision resulting from the informal provider claims dispute process. The OMPP expects that the MCE has the capacity to provide drilled down data descriptions from the plan's internal tracking systems to report on the reason types for disputes and resolution outcomes.
Performance Measures	The MCE must determine a resolution within 30 days of receiving the provider's informal dispute. The MCE must determine a resolution within 45 calendar days of receiving a provider's written formal dispute.
Item 1	Enter the total disputes received in the current reporting quarter. Segment the disputes received between informal and formal.
Item 2	Enter the total disputes received in the prior reporting quarter that were still pending resolution at the end of the last reporting quarter. Segment the disputes pending between informal and formal.
Item 3	This is a calculated field. Item 1 plus Item 2.

Item 4	Enter the total disputes resolved in the current reporting quarter, regardless of the quarter in which the dispute was received. Segment the disputes received between informal and formal.
Item 5	This is a calculated field. Item 4 divided by Item 3.
Item 6	For informal disputes, enter the number that were resolved within 30 days of receipt.
Item 7	For informal disputes, enter the number that were resolved beyond 30 days of receipt.
Item 8	For formal disputes, enter the number that were resolved within 45 days of receipt.
Item 9	For formal disputes, enter the number that were resolved beyond 45 days of receipt.
Item 10	This is a calculated field. Item 6 divided by Item 4.
Item 11	This is a calculated field. Item 8 divided by Item 4.
Item 12	Enter the total informal and formal disputes that were resolved and rendered in favor of the provider.
Item 13	Enter the total informal and formal disputes that were resolved and rendered in favor of the MCE.
Item 14	Enter the total informal and formal disputes in which the resolution decision is pending.
Item 15	This is a validation field. It measures whether the sum of Items 12 and 13 equals the total disputes resolved as reported in Item 4.
Item 16	This is a calculated field. It looks up the total number of clean claims received for 837I, 837P and 837D claims as reported on Report 0101, Item 3.
Item 17	This is a calculated field to benchmark the volume of provider claim disputes against claims received. The formula is Item 3 divided by Item 16, then multiplied by 100,000.

Report Number	**0304**
Report Title	**Report 0304: Provider Credentialing**
Purpose	To monitor the volume and timeliness of the MCE's credentialing system.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Not applicable
Data Reported Each Submission	For submissions April 30: Provider Credentialing Initiated or Completed in Period Jan 1 – Mar 31 For submissions July 31: Provider Credentialing Initiated or Completed in Period Apr 1 – June 30 For submissions Oct 31: Provider Credentialing Initiated or Completed in Period July 1 – Sept 30 For submissions Jan 31: Provider Credentialing Initiated or Completed in Period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Item 1	Enter the total number of enrolled providers with the MCE as of the last day of the reporting period for which, per NCQA guidelines, credentialing (and recredentialing) is required.
Item 2	Enter the total number of providers for which, per NCQA guidelines, credentialing (and recredentialing) was initiated in the reporting quarter.
Item 3	Enter the total number of providers for which credentialing or recredentialing was completed in the reporting quarter. For this measure, completed means a decision as a result of a Level 1 review, a Level 2 review, or a decision by the MCE credentialing committee.
Item 4	Enter the number of providers among those reported in Item #3 for which only a Level 1 review was completed. A Level 1 review is also referred to as a "clean" review, i.e. the provider was not presented to the MCE credentialing committee for review.
Item 5	This is a calculated field. Item 4 divided by Item 3.
Item 6	Enter the number of providers among those reported in Item #3 for which only a Level 2 review was completed. A Level 2 review means that the provider was presented to the MCE credentialing committee for review.
Item 7	This is a calculated field. Item 6 divided by Item 3.
Item 8	Enter the number of providers among those reported in Item #3 for which the MCE decided not to credential or recredential the provider for any reason.
Item 9	This is a calculated field. Item 8 divided by Item 3.
Item 10	For those providers whose credentialing or recredentialing process was completed during the reporting quarter, identify the average number of business days to complete the credentialing process. To report this measure, use the date when the provider submitted the application as the beginning date and the date when the credentialing or recredentialing application was fully processed as the end date. Numerator = Total number of business days to process all credentialing applications; Denominator = Total number of credentialing applications processed

Report Number	**0305**
Report Title	**Report 0305: Timeliness of Requests to Join Provider Network**
Purpose	To monitor the entire amount of time it takes a health plan to fully process a provider's request for participation in their health plan network. This process includes provider enrollment, credentialing (*if required based upon the requesting provider*), and contracting with a health plan.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Not applicable
Data Reported Each Submission	For submissions April 30: Network Participation Requests Received in Period Jan 1 – Mar 31 For submissions July 31: Network Participation Requests Received in Period Apr 1 – June 30 For submissions Oct 31 Network Participation Requests Received in Period July 1 – Sept 30 For submissions Jan 31: Network Participation Requests Received in Period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC combined
Specifications Used to Guide Definition	**Clean –** This should report on all requests for network participation received during the reporting quarter that were free of errors and could be processed without return to the provider for revisions or clarifications. Requests include all required steps for network participation, including enrollment, credentialing, contracting, and MCE system loading. **Unclean** – This should report on all requests for network participation received during the reporting quarter that contained at least one error necessitating a return of the provider information back to the provider for corrections. Requests include all required steps for network participation, including enrollment, credentialing, contracting, and MCE system loading. For each reporting item, please provide the number of clean provider network participation requests and the number of unclean provider network participation requests received. If the MCE receives both a clean request and an unclean request from a provider, the MCE should default to reporting only the clean request since the unclean request will be disregarded. **Enrollment -** The process of loading a contracted and credentialed provider for claims payment and appearance in the provider directory (if applicable). **Credentialing -** The process of reviewing the qualifications and appropriateness of a provider to join the MCE's network. **New Contracts -** Brand new providers are those providers that are not currently contracted with the MCE or part of a group that is currently contracted with the MCE.

	Existing Contracts – The MCE already has a signed contract with a provider group but is needing to add individual practitioners to it.
Item 1	Enter the total number of requests for provider network participation received during the **reporting quarter** for brand new provider contracts (this includes any brand-new group enrollments). Brand new providers are those providers that are not currently contracted with the MCE or part of a group that is contracted with the MCE. This should include all provider types (professional, ancillary, and facility). The definition of a request for network participation is the formal first step a provider takes to initiate the enrollment, credentialing, and contracting process with the MCE. This includes the completion of either an online or paper provider network participation form. Receipt of the provider participation form is prior to receiving a contract or loading the provider's information into the MCEs' systems, including the provider directory.
Item 2	Of the total number of requests for network participation from Item 1, enter the total number of providers that were fully enrolled, credentialed, and contracted during the reporting quarter. To have completed the provider network participation process, providers should be fully enrolled, credentialed (*if applicable*), contracted with the health plan, loaded into the MCE's system, capable of receiving claims payment from the health plan, and have had a provider welcome letter distributed. Distribution of the provider welcome letter stands for mailing or emailing the formal notification of enrollment/contract approval to the provider *after* they have been entered into the MCE's system.
Item 3	Of the total number of requests for network participation from Item 1, enter the total number of requests that were denied during the reporting quarter due to provider enrollment. A denial is counted if the health plan was unable to begin the credentialing process for the provider. If credentialing was *not* required for the provider, a denial is counted if the health plan was unable to move into contracting with the provider. If a provider receives a formal denial and then submits an updated network participation request, the request should be counted as a new request for network participation.
Item 4	Of the total number of requests for network participation from Item 1, enter the total number of requests that were denied during the reporting quarter due to provider credentialing.
Item 5	Of the total number of requests for network participation from Item 1, enter the total number that were denied during the reporting quarter due to provider contracting dispute. This would also include addendums to add new providers to an existing contract.

	A denial is counted if the provider declined to contract with the MCE after receiving the contract or the MCE declined to contract with the provider. This is separate from Items 3 and 4 whereas the provider did not reach the contracting process.
Item 6	Of the total number of requests for network participation from Item 1, enter the total number of providers that are still awaiting network participation due to provider enrollment or credentialing not being completed at the end of the reporting period. Only providers that submitted a request for network participation but have not yet begun the contracting process at the end of the quarter should be reported.
Item 7	Of the total number of requests for network participation from Item 1, enter the total number of provider contracts that are still pending completion at the end of the reporting period. Only providers that submitted a request for network participation and were still pending finalization of the contract (agreement and signature from either the provider or the MCE) at the end of the quarter should be reported.
Item 8	For all network participation requests in the quarter, enter the average number of calendar days from the date a request was received to the date of full completion of a provider contract. To have completed the provider network participation process, providers should be fully enrolled, credentialed (*if applicable*), contracted with the health plan, loaded into the MCE's system, capable of receiving claims payment from the health plan, and have had a provider welcome letter distributed. Distribution of the provider welcome letter stands for the date the notification letter was mailed or emailed to the provider after they have been entered into the MCE's system. If a practitioner has requested to join multiple contracts, each request should be considered individually for total turnaround time.
Item 9	For requests for network participation that are still pending at the end of the reporting quarter, enter the number of calendar days for the longest open request as calculated from the network participation receipt date. This should include all providers with pending network participation request decisions, including providers who are required to submit additional information for the health plan to render a participation decision.
Item 10	Enter the total number of requests for network participation received during the **reporting quarter** for providers that are being added to existing provider contracts. This should include all provider types (professional, ancillary, and facility). The definition of a request for network participation is the formal first step a provider takes to initiate the enrollment, credentialing, and contracting process with the MCE. This includes the completion of either an online or paper provider network participation form. Receipt of the provider

	participation form is prior to receiving a contract or loading the provider's information into the MCEs' systems, including the provider directory.
Item 11	Of the total number of requests for network participation for providers being added to existing contract providers from Item 10, enter the total number of providers that were fully enrolled, credentialed, and contracted during the **current quarter**. To have completed the provider network participation process, providers should be fully enrolled, credentialed (*if applicable*), contracted with the health plan, loaded into the MCE's system, capable of receiving claims payment from the health plan, and have had a provider welcome letter distributed. Distribution of the provider welcome letter stands for mailing or emailing the formal notification of enrollment/contract approval to the provider *after* they have been entered into the MCE's system.
Item 12	Of the total number of requests for network participation for providers being added to existing contract providers from Item 10, enter the total number of requests for network participation that were denied during the reporting quarter due to provider enrollment. A denial is counted if the health plan was unable to begin the credentialing process for the provider. If credentialing was *not* required for the provider, a denial is counted if the health plan was unable to move into contracting with the provider. If a provider receives a formal denial and then submits an updated network participation request, the request should be counted as a new request for network participation.
Item 13	Of the total number of requests for network participation for providers being added to existing contract providers from Item 10, enter the total number of requests for network participation that were denied during the reporting quarter due to provider credentialing.
Item 14	Of the total number of requests for network participation for providers being added to existing contract providers from Item 10, enter the total number of requests for network participation that were denied during the reporting quarter due to provider contracting disputes. This would also include addendums to add new providers to an existing contract. A denial is counted if the provider declined to contract with the MCE after receiving the contract or the MCE declined to contract with the provider. This is separate from Items 3 and 4 whereas the provider did not reach the contracting process.
Item 15	Of the total number of requests for network participation for providers being added to existing contract providers from Item 10, enter the total number of providers that were still awaiting network participation due to provider enrollment or credentialing completion by the end of the reporting

	period. The number reported should only be the number of providers that submitted a request for network participation but had not yet begun the contracting process.
Item 16	Of the total number of requests for network participation for providers being added to existing contract providers from Item 10, enter the total number of provider contracts that were still pending completion by the end of the reporting period. The number reported should only be the number of providers that submitted a request for network participation and were still pending finalization of the contract (agreement and signature from either the provider or the MCE).
Item 17	For all network participation requests for providers being added to existing contract providers in the quarter, enter the average number of calendar days from the date a request was received to the date of full completion of a provider contract. To have completed the provider network participation process, providers should be fully enrolled, credentialed (*if applicable*), contracted with the health plan, loaded into the MCE's system, capable of receiving claims payment from the health plan, and have had a provider welcome letter distributed. Distribution of the provider welcome letter stands for the date the notification letter was mailed or emailed to the provider after they have been entered into the MCE's system. If a practitioner has requested to join multiple contracts, each request should be considered individually for total turnaround time.
Item 18	For requests for network participation for providers being added to existing contract providers that are still pending at the end of the reporting quarter, enter the number of calendar days for the longest open request as calculated from the network participation receipt date.

Item 19	For the numbers reported in item 6, 7, 15 and 16, list out the following:
	• Provider Name
	• Provider NPI
	• Date Request for Network Participation Received
	• Reason Still Pending – MCE will use the most appropriate of the reasons below for why the request for network participation is still pending.
	  o Enrollment
	  o Credentialing
	  o Contracting
	
	Please add as many rows as needed to report all provider enrollments and contracts that are still pending.

Item 20	When an MCE negotiates a retroactive effective date outside of the standard network participation

	effective date policy, the MCE must provide notification to OMPP through the submission of this *Timeliness of Requests to Join Provider Network* Report. For the network participation requests received in the quarter being reported that did not have an effective date assigned following the standard network participation effective date policy, please list the following: • Provider Name • Provider NPI • Date Request for Network Participation Received • Effective Date Assigned • Reason For Effective Date – MCE will populate the most appropriate of the reasons below forwhy the request was assigned a non-standard effective date. o Best interest of member care o Change in ownership o Change in provider enrollment type or classification o Requested by FQHC or RHC o Delegated Provider *Please add as many rows as needed to report all non-standard negotiated provider network participation effective dates.*
Comments Box	This space should be used for a health plan to add any additional context to the numbers being reported.

Report Number	**0401**
Report Title	**Report 0401: HEDIS Child Preventive Care Measures**
Purpose	To assess the percentage of members who had a well-child visit during the reporting period using MCE claims only. Three separate measures are reported. The specifications for each measure mimic the annual HEDIS measure specifications: • Members who had a Well-Child Visits in the First 30 Months of Life (HEDIS W30). • Members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year (HEDIS WCV). • Childhood Immunization Status (HEDIS CIS) Combo 10. It captures the percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Yes, 90 days following the anchor date (last day) of the reporting period
Data Reported Each Submission	This is a rolling 12-month report. Data should be refreshed with each quarter's submission. The anchor date is the last day of the 12-month reporting period. For submissions April 30: Experience Period is Jan 1 – Dec 31 For submissions July 31: Experience Period is Apr 1 – Mar 31 For submissions Oct 31: Experience Period is July 1 – June 30 For submissions Jan 31: Experience Period is Oct 1 – Sept 30
Lines of Business to Report	For W30, HHW only For WCV, HHW and HCC only For CIS, HHW and HCC only
Specifications Used to Guide Definition	Current year HEDIS Technical Specifications.
Continuous Enrollment Requirement	Please refer to HEDIS guidelines for continuous enrollment.
Any Other Deviations from HEDIS Specification	For HEDIS, the specification examines members age 3 through 21.
Item 1	For the W30 measure, the following rates are reported:

	1. *Well-Child Visits in the First 15 Months*. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. *Well-Child Visits for Age 15 Months–30 Months*. Children who turned 30 months old during the measurement year: Two or more well-child visits Report the number of members who had Six or more well-child visits (Well-Care Value Set) on different dates of service on or before the 15-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.
Item 2	Report the number of members enrolled with the MCE on the anchor date who turned 15 months old during the measurement period and who met continuous enrollment requirement. Calculate the 15-month birthday as the child's first birthday plus 90 days. The anchor date is the date when the child turns 15 months old.
Item 3	This is a calculated field to compute the measure. Item 1 divided by Item 2.
Item 4	Report the number of members with two or more well-child visits (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.
Item 5	Report the number of members enrolled with the MCE on the anchor date who turned 30 months of age during the measurement period and who met the continuous enrollment requirement. Calculate the 30-month birthday as the second birthday plus 180 days. The anchor date is when the child turns 30 months old.
Item 6	This is a calculated field to compute the measure. Item 4 divided by Item 5.
Item 7	Report the number of members who turned age 3 through 11years old during the measurement period and who had at least one well-care visit. Use the Well-Care Value Set from NCQA to define positive numerator hits. The visit may be with a PCP or an OB/GYN practitioner.
Item 8	Report the number of members enrolled with the MCE on the anchor date who turned age 3- through 11 years old during the measurement period and who met the continuous enrollment requirements as specified above.
Item 9	This is a calculated field to compute the measure. Item 7 divided by Item 8.
Item 10	Report the number of members who turned age 12 through 17 years old during the measurement period and who had at least one well-care visit. Use the Well-Care Value Set from NCQA to define positive numerator hits. The visit may be with a PCP or an OB/GYN practitioner.

Item 11	Report the number of members enrolled with the MCE on the anchor date who turned age 12 through 17 years old during the measurement period and who met the continuous enrollment requirements as specified above.
Item 12	This is a calculated field to compute the measure. Item 10 divided by Item 11.
Item 13	Report the number of members who turned age18 through 21 years old during the measurement period and who had at least one well-care visit. Use the Well-Care Value Set from NCQA to define positive numerator hits. The visit may be with a PCP or an OB/GYN practitioner.
Item 14	Report the number of members enrolled with the MCE on the anchor date who turned age 18 through 21 years old during the measurement period and who met the continuous enrollment requirements as specified above.
Item 15	This is a calculated field to compute the measure. Item 13 divided by Item 14.
Item 16	Report the number of members who turned 2 years old during the measurement period who had four diphtheria, tetanus, and acellular pertussis (DTaP). For DTaP, count only members that received at least four vaccinations with different dates of services on or before the child's second birthday. **Do not count a vaccination administered prior to 42 days after birth.**
Item 17	Report the number of members who turned 2 years old during the measurement period and met continuous enrollment requirements.
Item 18	This is a calculated field. Item16 divided by item 17.
Item 19	Report the number of members who receive three polio (IPV) vaccines by their second birthday. For IPV, count members who received at least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Immunization Value Set; Inactivated Polio Vaccine (IPV) Procedure Value Set), with different dates of service on or before the child's second birthday. **Do not count a vaccination administered prior to 42 days after birth.**
Item 20	Report the number of members who turned 2 years old during the measurement period and met continuous enrollment requirements.
Item 21	This is a calculated field. Item 19 divided by item 20.
Item 22	Report the number of members who received one measles, mumps and rubella (MMR) vaccine by their second birthday. For MMR, any of the following meet criteria: At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set; Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set) on or between the child's first and second birthdays.

<table>
<tr><td></td><td>At least one measles and rubella vaccination (Measles Rubella Immunization Value Set; Measles Rubella Vaccine Procedure Value Set) on or between the child's first and second birthdays and one of the following:
At least one mumps vaccination (Mumps Immunization Value Set; Mumps Vaccine Procedure Value Set) on or between the child's first and second birthdays.
History of mumps illness (Mumps Value Set) any time on or before the child's second birthday.
Any combination of codes from the table below that indicates evidence of all three antigens (on the same or different date of service).
<table>
<tr><th>Measles (any of the following)</th><th>Mumps (any of the following)</th><th>Rubella (any of the following)</th></tr>
<tr><td>At least one measles vaccination (Measles Immunization Value Set; Measles Vaccine Procedure Value Set) administered on or between the child's first and second birthdays.</td><td>At least one mumps vaccination (Mumps Immunization Value Set; Mumps Vaccine Procedure Value Set) administered on or between the child's first and second birthdays.</td><td>At least one rubella vaccination (Rubella Immunization Value Set; Rubella Vaccine Procedure Value Set) administered on or between the child's first and second birthdays.</td></tr>
<tr><td>History of measles (Measles Value Set) illness anytime on or before the child's second birthday.</td><td>History of mumps (Mumps Value Set) illness anytime on or before the child's second birthday.</td><td>History of rubella (Rubella Value Set) illness anytime on or before the child's second birthday.</td></tr>
</table></td></tr>
<tr><td>Item 23</td><td>Report the number of members who turned 2 years old during the measurement period and met continuous enrollment requirements</td></tr>
<tr><td>Item 24</td><td>This is a calculated field. Item 22 divided by item 23</td></tr>
<tr><td>Item 25</td><td>Report the number of members who received three haemophilus influenza type B (HiB) vaccine by their second birthday.</td></tr>
<tr><td>Item 26</td><td>Report the number of members who turned 2 years old during the measurement period and met continuous enrollment requirements.
For HiB, count members with at least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Immunization Value Set; Haemophilus Influenzae Type B (HiB) Vaccine Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.</td></tr>
</table>

Item 27	This is a calculated field. Item 25 divided by item 26.
Item28	Report the number of members who received three Hepatitis B (HepB) vaccine by their second birthday. For Hepatitis B, any of the following on or before the child's second birthday meet criteria: • At least three hepatitis B vaccinations (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set), with different dates of service. - One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8. • History of hepatitis illness (Hepatitis B Value Set).
Item 29	Report the number of members who turned 2 years old during the measurement period and met continuous enrollment requirements.
Item 30	This is a calculated field. Item 28 divided by item 29.
Item 31	Report the number of members who had one Chicken Pox (VZV) vaccine by their second birthday. For VZV, any of the following meet criteria: • At least one VZV vaccination (Varicella Zoster (VZV) Immunization Value Set; Varicella Zoster (VZV) Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays. • History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set) on or before the child's second birthday.
Item 32	Report the number of members who turned 2 years old during the measurement period and met continuous enrollment requirements.
Item 33	This is a calculated field. Item 31 divided by item 32.
Item 34	Report the number of members who turned 2 years old during the measurement period who had four pneumococcal conjugate (PCV) vaccines by their second birthday. For PVC the following meets the criteria: At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Immunization Value Set; Pneumococcal Conjugate Vaccine Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
Item 35	Report the number of members who turned 2 years old during the measurement period and met continuous enrollment requirements.
Item 36	This is a calculated field. Item 34 divided by item 35.

Item37	Report the number of members who turned 2 years old during the measurement period who had one on Hepatitis A (HepA) vaccine by their second birthday. For HepA, either of the following meets the criteria: • At least one hepatitis A vaccination (Hepatitis A Immunization Value Set; Hepatitis A Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays. • History of hepatitis A illness (Hepatitis A Value Set) on or before the child's second birthday.
Item 38	Report the number of members who turned 2 years old during the measurement period and met continuous enrollment requirements.
Item 39	This is a calculated field. Item 37 divided by item 38
Item 40	Report the number of members who turned 2 years old during the measurement period who had two or three rotavirus (RV) vaccines by their second birthday. For RV, any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth. • At least two doses of the two-dose rotavirus vaccine (Rotavirus (2 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) on different dates of service. • At least three doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set) on different dates of service. • At least one dose of the two-dose rotavirus vaccine (Rotavirus (2 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) and at least two doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set), all on different dates of service.
Item 41	Report the number of members who turned 2 years old during the measurement period and met continuous enrollment requirements.
Item 42	This is a calculated field. Item 40 divided by item 41
Item 43	Report the number of members who turned 2 years old during the measurement period who had two influenza (flu) vaccines by their second birthday. For the Flu, the following meets the criteria:

	At least two influenza vaccinations (Influenza Immunization Value Set; Influenza Vaccine Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 6 months (180 days) after birth. – One of the two vaccinations can be an LAIV vaccination (Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set) administered on the child's second birthday. Do not count an LAIV vaccination administered before the child's second birthday.
Item 44	Report the number of members who turned 2 years old during the measurement period and met continuous enrollment requirements.
Item 45	This is a calculated field. Item 43 divided by item 44.

Report Number	**0402**
Report Title	**Report 0402: HEDIS Other Measures**
Purpose	To provide quarterly updates on HEDIS measures using the administrative (claims) method only. For each measure, the total eligible population is included, not a sample. Twelve separate measures are reported. The specifications for each measure mimic the annual HEDIS measure specifications: • AAP: Adults' Access to Preventive/Ambulatory Services • OED: Oral Evaluation, Dental Services • BCS: Breast Cancer Screening • CCS: Cervical Cancer Screening • AMR Asthma Medication Ratio • HBD: Hemoglobin A1c Control for Patients with Diabetes • PPC: Prenatal and Postpartum Care • FUH: Follow-up After Hospitalization for Mental Illness • FUM: Follow-up After Emergency Dept Visit for Mental Illness • FUA: Follow-up After Emergency Dept Visit for Substance Use • IET: Initiation and Engagement of Substance Use Disorder Treatment
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Yes, 90 days following the anchor date (last day) of the reporting period
Data Reported Each Submission	This is a rolling 12-month report. Data should be refreshed with each quarter's submission. The anchor date depends on the measure. The anchor date for AAP, BCS, CCS, AMR, and HBD is the last day of the 12-month reporting period. For submissions April 30: Reporting Period is Dec 31, Experience Period is Jan 1 – Dec 31 For submissions July 31: Reporting Period is Mar 31, Experience Period is Apr 1 – Mar 31 For submissions Oct 31: Reporting Period is June 30, Experience Period is July 1 – June 30 For submissions Jan 31: Reporting Period is Sept 30, Experience Period is Oct 1 – Sept 30 The anchor date for PPC is the date of delivery. Select the number of women that delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For submissions April 30: Reporting Period is Dec 31, Experience Period is Oct 8 – Oct 7 For submissions July 31: Reporting Period is Mar 31, Experience Period is Jan 6 – Jan 5 For submissions Oct 31: Reporting Period is June 30, Experience Period is Apr 6 – Apr 5

	For submissions Jan 31: Reporting Period is Sept 30, Experience Period is Jul 5 – Jul4 There is not a specific anchor date for FUH, FUM and FUA, but rather an experience period that ends 31 days prior to the last day of the 12-month reporting period. For submissions April 30: Reporting Period is Dec 31, Experience Period is Jan 1 – Dec 1 For submissions July 31: Reporting Period is Mar 31, Experience Period is Apr 1 – Mar 1 For submissions Oct 31: Reporting Period is June 30, Experience Period is July 1 – May 31 For submissions Jan 31: Reporting Period is Sept 30, Experience Period is Oct 1 – Aug 31 There is not a specific anchor date for IET, but rather an experience period that ends 47 days prior to the last day of the 12-month reporting period. For submissions April 30: Reporting Period is Dec 31, Experience Period is Jan 1 – Nov 14 For submissions July 31: Reporting Period is Mar 31, Experience Period is Apr 1 – Feb 2 For submissions Oct 31: Reporting Period is June 30, Experience Period is July 1 – Apr 13 For submissions Jan 31: Reporting Period is Sept 30, Experience Period is Oct 1 – July 14
Lines of Business to Report	The measures to report for HHW are: • AMR, age 5-11 and age 12-18 • OED, age 0-2 years, 3-5 years, 6-14 years, 15-20 years, and total • PPC • FUH All measures are required to be reported for each of the three segments of HIP except: • AAP, age 65 and over • OED, age 0-2, 3-5 years, and 6-14 years • AMR, age 5-11 and age 12-18 All measures are required for HCC except: • FUM • FUA
Specifications Used to Guide Definition	Current year HEDIS Technical Specifications.
Continuous Enrollment Requirement	Please refer to HEDIS guidelines for continuous enrollment.
Any Other Deviations from HEDIS Specification	For the FUH, FUM, FUA and IET measures, OMPP considers all ages by line of business. HEDIS breaks each of these measures into age groups.

Item 1	Report the number of members who were age 20 to 44 years old as of the end of the measurement period and who had an ambulatory or preventive care visit. Use the following value sets from NCQA to identify ambulatory or preventive care visits to define positive numerator hits: Ambulatory Visits Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set) Other Ambulatory Visits Value Set, with or without a telehealth modifier Telephone Visits Value Set Online Assessments Value Set
Item 2	Report the number of members who were age 45 to 64 years old as of the end of the measurement period and who had an ambulatory or preventive care visit. Use the value sets in Item 1 to identify ambulatory or preventive care visits to define positive numerator hits.
Item 3	Report the number of members who were age 65 and older as of the end of the measurement period and who had an ambulatory or preventive care visit. Use the value sets in Item 1 to identify ambulatory or preventive care visits to define positive numerator hits.
Item 4	Report the number of members age 20 to 44 at the end of the measurement period and who met the continuous enrollment requirements as specified above.
Item 5	Report the number of members age 45 to 64 at the end of the measurement period and who met the continuous enrollment requirements as specified above.
Item 6	Report the number of members age 65 and older at the end of the measurement period and who met the continuous enrollment requirements as specified above.
Item 7	This is a calculated field to compute the measure. Item 1 divided by Item 4.
Item 8	This is a calculated field to compute the measure. Item 2 divided by Item 5.
Item 9	This is a calculated field to compute the measure. Item 3 divided by Item 6.
Item 10	Report the number of members age 0-2 years at the end of the measurement period who had at least one comprehensive or periodic oral evaluation.
Item 11	Report the number of members age 3-5 years at the end of the measurement period who had at least one comprehensive or periodic oral evaluation.
Item 12	Report the number of members age 6-14 years at the end of the measurement period who had at least one comprehensive or periodic oral evaluation.
Item 13	Report the number of members age 15-20 years at the end of the measurement period who had at least one comprehensive or periodic oral evaluation.
Item 14	Report the total number of members age 0-20 years at the end of the measurement period who had at least one comprehensive or periodic oral evaluation.
Item 15	Report the number of members age 0-2 years at the end of the measurement period who meet the continuous enrollment requirement for the measure.
Item 16	Report the number of members age 3-5 years at the end of the measurement period who meet the continuous enrollment requirement for the measure.

Item 17	Report the number of members age 6-14 years at the end of the measurement period who meet the continuous enrollment requirement for the measure.
Item 18	Report the number of members age 15-20 years at the end of the measurement period who meet the continuous enrollment requirement for the measure.
Item 19	Report the number of members age 0-20 years at the end of the measurement period who meet the continuous enrollment requirement for the measure.
Item 20	This is a calculated field to compute the measure. Item10 divided by Item 15.
Item 21	This is a calculated field to compute the measure. Item 11 divided by Item 16
Item 22	This is a calculated field to compute the measure. Item 12 divided by Item 17.
Item 23	This is a calculated field to compute the measure. Item 13 divided by Item 18.
Item 24	This is a calculated field to compute the measure. Item 14 divided by Item 19.
Item 25	Report the number of female members who were age 50 to 74 years old as of the end of the measurement period. Use the following Mammography Value Set from NCQA to identify positive numerator hits.
Item 26	Report the number of female members enrolled with the MCE on the anchor date who were age 50 to 74 on the anchor date.
Item 27	Report the number of female members in Item 29 who either did not meet the continuous enrollment requirements as specified above or were excluded for other reasons as per the BCS specification.
Item 28	This is a calculated field. Item 26 minus 27.
Item 29	This is a calculated field to compute the measure. Item 25 divided by 28.
Item 30	Report the number of female members who were age 21 to 64 years old as of the end of the measurement period and who were screened for cervical cancer. Numerator hits can be achieved in one of two steps: Step 1 is women age 21 to 64 as of the end of the measurement period who had cervical cytology (Cervical Cytology Value Set from NCQA) during the measurement year or the two years prior to the measurement year. Step 2 is women who did not meet the Step 1 criteria age 30 to 64 as of the end of the measurement year who had cervical cytology and an HPV test (HPV Tests Value Set) with service dates four or less days apart in the measurement year or the four years prior to the measurement year.
Item 31	Report the number of female members enrolled with the MCE on the anchor date who were age 21 to 64 on the anchor date who had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year
Item 32	Report the number of female members in Item 34 who either did not meet the continuous enrollment requirements as specified above or were excluded for other reasons as per the CCS specification.
Item 33	This is a calculated field. Item 31 minus 32.
Item 34	This is a calculated field to compute the measure. Item 30 divided by item 33.

Item 35	Report the number of members who were age 5 to 11 years old as of the end of the measurement period, were eligible in the denominator for this measure with persistent asthma and who have a ratio of controller medications to total asthma medications of 0.50 or greater. The specifications for the AMR measure mimic the annual HEDIS measure requirements.
Item 36	Report the number of members age 5 to 11 at the end of the measurement period who received asthma medications and were not excluded for lack of continuous enrollment or other measure specifications.
Item 37	This is a calculated field to compute the measure. Item 35 divided by item 36.
Item 38	Report the number of members age 12-18 at the end of the measurement period with persistent asthma who have a ratio of controller medications to total asthma medications of 0.50 or greater.
Item 39	Report the number of members age 12-18 at the end of the measurement period who received asthma medications and were not excluded for lack of continuous enrollment or other measure specifications.
Item 40	This is a calculated field to compute the measure. Item 38 divided by item 39.
Item 41	Report the number of members age 19-50 at the end of the measurement period with persistent asthma who have a ratio of controller medications to total asthma medications of 0.50 or greater%.
Item 42	Report the number of members age 19-50 at the end of the measurement period who received asthma medications and were not excluded for lack of continuous enrollment or other measure specifications.
Item 43	This is a calculated field to compute the measure. Item 41 divided by Item 42.
Item 44	Report the number of members age 51-64 at the end of the measurement period with persistent asthma who have a ratio of controller medications to total asthma medications of 0.50 or greater.
Item 45	Report the number of members age 51-64 at the end of the measurement period who received asthma medications and were not excluded for lack of continuous enrollment or other measure specifications.
Item 46	This is a calculated field. Item 44 divided by item 45.
Item 47	Report the number of members with diabetes who were age 18 to 75 as the end of the measurement period with HbA1c Control (<8.0%). Use the current year HEDIS Technical Specifications to determine numerator compliance.
Item 48	Report the number of members with diabetes who were age 18 to 75 as of the end of the measurement period with HbA1c Poor Control (>9%). Use the current year HEDIS Technical Specifications to determine numerator compliance.
Item 49	Report the number of members ages 18-75 at the end of the measurement period with Diabetes (Type 1 and 2) who were not excluded for continuous enrollment or who had required exclusions/exclusions. Refer to the current year HEDIS Technical Specifications to determine denominator compliance.
Item 50	This is a calculated field to compute the measure. Item 48 minus 49.
Item 51	This is a calculated field to compute the measure. Item 47 divided by 50.

Item 52	Report the number of members who delivered a baby that received a prenatal care visit as a member of the MCE in the first trimester or within 42 days of enrollment with the MCE. Follow the steps identified in the PPC specification along with the decision rules to identify the numerator.
Item 53	Report the number of members who delivered a baby that received a postpartum visit on or between7 and 84 days after delivery. Use the following NCQA value sets to define postpartum visits: Postpartum Visits Value Set, Cervical Cytology Lab Test Value Set, Cervical Cytology Result or Finding Value Set, Postpartum Bundled Services Value Set
Item 54	Select women who delivered a live birth at some time on or before 43 days prior to the start of reporting period and 60 days prior to the end of the reporting period
Item 55	Report the number of women in Item 54 who either **did not meet the continuous enrollment requirements or were excluded** for other reasons as per the PPC specification.
Item 56	This is a calculated field. Item 54 minus Item 55.
Item 57	This is a calculated field to compute the measure. Item 52 divided by Item 56.
Item 58	This is a calculated field to compute the measure. Item 53 divided by Item 56.
Item 59	Report the number of acute inpatient discharges with a principal diagnosis of mental illness during the measurement year in which a follow-up visit with a mental health provider occurred within 7 days of the discharge. There are nine criteria that encompass 12 value sets that may be used to identify follow-up visits.

Item 60	Report the number of acute inpatient discharges with a principal diagnosis of mental illness during the measurement year in which a follow-up visit with a mental health provider occurred within 30 days of the discharge. There are nine criteria that encompass 12 value sets that may be used to identify follow-up visits.
Item 61	Report the number of acute inpatient discharges with a principal diagnosis of mental illness or intentional self-harm that occurred during days 1 and 335 of the measurement year that do not meet the exclusion criteria as per the FUH specification. Use the Inpatient Stay Value Set to identify discharges and the Nonacute Inpatient Stay Value Set to identify exclusions. Use the Mental Health Diagnosis Value Set and the Intentional Self-Harm Value Set to identify the specific inpatient discharges to include. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
Item 62	This is a calculated field to compute the measure. Item 59 divided by Item 61.
Item 63	This is a calculated field to compute the measure. Item 60 divided by 61.

Item 64	Report the number of ED visits for members 18 years of age and older with a principal diagnosis of mental illness during the measurement year with a follow-up visit to any practitioner within 7 days of the ED visit. There are 16 criteria that encompass 13 value sets that may be used to identify follow-up visits.
Item 65	Report the number of ED visits for members 18 years of age and older with a principal diagnosis of mental illness during the measurement year with a follow-up visit to any practitioner within 30 days of the ED visit. There are 16 criteria that encompass 13 value sets that may be used to identify follow-up visits.
Item 66	Report the number of ED visits for members 18 years of age and older with a principal diagnosis of mental illness or intentional self-harm that occurred during the measurement year that do not meet the exclusion criteria as per the FUM specification. Use the ED Value Set to identify ED visits, then filter these by using the Mental Illness Value Set and the Intentional Self-Harm Value Set to identify the specific ED visits to include. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and **do not include more than one visit per 31-day.**
Item 67	This is a calculated field to compute the measure. Item 64 divided by 66.
Item 68	This is a calculated field to compute the measure. Item 65 divided by 66.
Item 69	Report the number of ED visits for members 18 years of age and older with a principal diagnosis of substance use disorder (SUD), or any drug overdose during the measurement year with a follow-up visit within 7 days of the ED visit. There are 6 criteria that encompass 10 value sets that may be used to identify follow-up visits.
Item 70	Report the number of ED visits for members 18 years of age and older with a principal diagnosis of substance use disorder (SUD), or any drug overdose during the measurement year with a follow-up visit for within 30 days of the ED visit. Use the 2022 HEDIS criteria and value sets to identify follow-up visits.
Item 71	Report the number of ED visits for members 18 years of age and older with a principal diagnosis of substance use disorder (SUD), or any drug overdose that occurred during the measurement year that do not meet the exclusion criteria as per the FUA specification. Use the ED Value Set to identify ED visits, then filter these by using the AOD Abuse and Dependence Value Set or any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) to identify the specific ED visits to include. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period.
Item 72	This is a calculated field to compute the measure. Item 69 divided by 71.
Item 73	This is a calculated field to compute the measure. Item 70 divided by 71.

Item 74	Report the number of members age 18 and over as of the end of the measurement period with alcohol use disorder who initiated treatment within 14 days of the diagnosis. The intake Period is November 15 of the year prior to the measurement year–November 14 of the measurement year. The Intake Period is used to capture new SUD episodes. An SUD episode is an encounter during the Intake Period with a diagnosis of SUD. Establish an Index Episode Start Date (IESD). The IESD may be established through an AOD inpatient admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth or medication treatment. An SUD episode date is the date of service for an encounter during the Intake period with a diagnosis of SUD. *For visits that result in an inpatient stay*, the inpatient discharge is the SUD Episode (an SUD diagnosis is not required for the inpatient stay; use the diagnosis from the visit that resulted in the inpatient stay to determine the diagnosis cohort). *For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, or ED visit (not resulting in an inpatient stay)*, the SUD Episode Date is the date of service. *For an inpatient stay or for medically managed withdrawal event* (i.e., detoxification) that occurred during an inpatient stay, the SUD Episode Date is the date of discharge. *For medically managed withdrawal* (i.e., detoxification), other than those that occurred during an inpatient stay, the SUD Episode Date is the date of service. *For direct transfers*, the SUD Episode Date is the discharge date from the last admission (an SUD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort). For an opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the SUD Episode Date, negative diagnosis history and numerator events). Use a period of 194 days of negative diagnosis history to establish new IESDs. Use the 2022 HEDIS criteria and value sets to identify initiation.
Item 75	Report the number of members age 18 and over as of the end of the measurement period with opioid use disorder who initiated treatment within 14 days of the diagnosis. Use the criteria described in Item 77 to identify initiation.
Item 76	Report the number of members age 18 and over at of the end of the measurement period with other substance use disorder who initiated treatment within 14 days of the diagnosis.

	Use the criteria described in Item 77 to identify initiation.
Item 77	This is a calculated field. Item 74 plus Item 75 plus Item 76.
Item 78	Report the number of members age 18 and over at of the end of the measurement period with alcohol use disorder who initiated treatment that have evidence of treatment engagement within 34 days of the initiation. Use the HEDIS criteria and value sets to identify engagement.
Item 79	Report the number of members age 18 and over as of the end of the measurement period with opioid use disorder that have evidence of treatment engagement within 34 days of initiation. Use the criteria described in Item 81 to identify engagement.
Item 80	Report the number of members age 18 and over as of the end of the measurement period with other substance use disorder that have evidence of treatment engagement within 34 days of the initiation. Use the criteria described in Item 81 to identify engagement.
Item 81	This is a calculated field. Item 78 plus Item 79 plus Item 80.
Item 82	Report the number of new episodes of alcohol use disorder for members age 18 and over that do not meet exclusion criteria as per the IET specification.
Item 83	Report the number of new episodes of opioid use disorder for members age 18 and over that do not meet exclusion criteria as per the IET specification.
Item 84	Report the number of new episodes of other substance use disorder for members age 18 and over that do not meet exclusion criteria as per the IET specification.
Item 85	This is a calculated field. Item 82 plus Item 83 plus Item 84.
Item 86	This is a calculated field to compute the measure. Item 74 divided by Item 82.
Item 87	This is a calculated field to compute the measure. Item 75 divided by Item 83.
Item 88	This is a calculated field to compute the measure. Item 76 divided by Item 84.
Item 89	This is a calculated field to compute the measure. Item 77 divided by Item 85.
Item 90	This is a calculated field to compute the measure. Item 78 divided by Item 82.
Item 91	This is a calculated field to compute the measure. Item 79 divided by Item 83.
Item 92	This is a calculated field to compute the measure. Item 80 divided by Item 84.
Item 93	This is a calculated field to compute the measure. Item 81 divided by Item 85.

Report Number	**0403**
Report Title	**Report 0403: AHRQ Prevention Quality Indicator (PQI) Measures**
Purpose	To provide quarterly updates on Agency for Healthcare Research and Quality (AHRQ) PQI measures using the administrative (claims) method only. For each measure, the total eligible population is included, not a sample. Four separate measures are reported. The specifications for each measure mimic the AHRQ measure specifications: • PQI 01: Diabetes Short-Term Complications Admission Rate • PQI 05: COPD or Asthma in Older Adults Admission Rate • PQI 08: Heart Failure Admission Rate • PQI 15: Asthma in Younger Adults Admission Rate
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Yes, 90 days following the anchor date (last day) of the reporting period
Data Reported Each Submission	This is a rolling 12-month report. Data should be refreshed with each quarter's submission. The anchor date for each measure on this report is the last day of the 12-month reporting period. For submissions April 30: Reporting Period is Dec 31, Experience Period is Jan 1 – Dec 31 For submissions July 31: Reporting Period is Mar 31, Experience Period is Apr 1 – Mar 31 For submissions Oct 31: Reporting Period is June 30, Experience Period is July 1 – June 30 For submissions Jan 31: Reporting Period is Sept 30, Experience Period is Oct 1 – Sept 30 The denominator is determined based on the enrollment on the last day of the 12-month reporting period.
Lines of Business to Report	HIP (Basic, Plus and State Plan separate) and HCC
Specifications Used to Guide Definition	PQI 01 Diabetes Short-Term Complications Admission Rate, June 2021 PQI 05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate, June 2018 PQI 08 Heart Failure Admission Rate, June 2021 PQI 15 Asthma in Younger Adults Admission Rate, June 2021
Continuous Enrollment Requirement	No. Track all numerator events and divide by the point-in-time enrollment as defined in the denominator as of the last day of the reporting period.
Any Other Deviations from AHRQ Specification	No

Item 1	Enter the number of discharges for members age 18 and older at the end of the measurement period with a principal diagnosis of diabetes short-term complications. Use the PQI 01 value set ACDIASD to identify the discharges. Use the PQI 01 specification to define numerator exclusions.
Item 2	Enter the number of discharges for members age 40 and older at the end of the measurement period with a principal diagnosis of COPD or asthma. Use the PQI 05 value sets ACCOPDD and ACSASTD to identify the discharges. Use the PQI 05 specification to define numerator exclusions.
Item 3	Enter the number of discharges for members age 18 and older at the end of the measurement period with a principal diagnosis of heart failure. Use the PQI 08 value set MRTCHFD to identify the discharges. Use the PQI 08 specification to define numerator exclusions.
Item 4	Enter the number of discharges for members age 18 to 39 at the end of the measurement period with a principal diagnosis of asthma. Use the PQI 15 value set ACASTD to identify the discharges. Use the PQI 15 specification to define numerator exclusions.
Item 5	Enter the total member months for members age 18 and over during the measurement period.
Item 6	Enter the total member months for members age 40 and over during the measurement period
Item 7	Enter the total member months for members age 18 to 39 during the measurement period
Item 8	This is a calculated field to compute the measure. Item 1 divided by Item 5, then multiplied by 100,000.
Item 9	This is a calculated field to compute the measure. Item 2 divided by Item 6, then multiplied by 100,000.
Item 10	This is a calculated field to compute the measure. Item 3 divided by Item 5, then multiplied by 100,000.
Item 11	This is a calculated field to compute the measure. Item 4 divided by Item 7, then multiplied by 100,000.

Report Number	**0501**
Report Title	**Report 0501: Inpatient Discharge Report**
Purpose	To assess trends in inpatient hospital stays by DRG categories for both average length of stay and payment per discharge.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Yes, 90 days following the anchor date (last day) of the reporting period
Data Reported Each Submission	This is a rolling 12-month report. Data should be refreshed with each quarter's submission. The anchor date for each measure on this report is the last day of the 12-month reporting period. For submissions April 30: Reporting Period is Dec 31, Experience Period is Jan 1 – Dec 31 For submissions July 31: Reporting Period is Mar 31, Experience Period is Apr 1 – Mar 31 For submissions Oct 31: Reporting Period is June 30, Experience Period is July 1 – June 30 For submissions Jan 31: Reporting Period is Sept 30, Experience Period is Oct 1 – Sept 30
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	Use the most recent version of the APR-DRG Grouper . All MCE paid inpatient discharges should be categorized by the APR-DRG assignment and severity of illness (SOI) assignment that the software assigns after the patient discharges. In the event that a discharge was paid by the MCE that does not map to an APR-DRG, or if the MCE paid for inpatient discharges outside of the APR-DRG grouper methodology, the discharges should be reported at the bottom of the report on the row 'Inpatient Stays Not Paid APR-DRG'. The calculated rows at the top of the report sum the cases below it at the APR-DRG level such that each APR-DRG/SOI is assigned to one of the subtotal lines. The sum of the information on each subtotal line then rolls up to the Total All Discharges line.
Continuous Enrollment Requirement	No
Column A	The APR-DRG number is pre-populated on the report.
Column B	The SOI level for each DRG is pre-populated on the report.
Column C	The DRG description is pre-populated on the report.
Column D	On the top row for each line of business, enter the unique number of members that had an inpatient stay in the reporting period. If the same member had multiple inpatient stays during the reporting period, count the member only once in this cell. Enter the total paid discharges assigned to each APR-DRG/SOI category for the experience period.

Column E	Enter the sum of the days, included non-covered or non-paid days, for the paid discharges assigned to each APR-DRG/SOI category reported in Column D.
Column F	Enter the sum of the payments made by the MCE for the paid discharges assigned to each APR-DRG/SOI category reported in Column D.
Column G	These are calculated fields. For each row, the value in Column E is divided by the value in Column D.
Column H	These are calculated fields. For each row, the value in Column F is divided by the value in Column D.

Report Number	**0502**
Report Title	**Report 0502: Inpatient Readmissions Report**
Purpose	To summarize the rate at which MCE members are readmitted post-discharge.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Yes, 90 days following the anchor date (last day) of the reporting period
Data Reported Each Submission	This is a rolling 12-month report. Data should be refreshed with each quarter's submission. The anchor date for each measure on this report is 30 days prior to the end of the measurement period. For submissions April 30: Reporting Period is through Dec 31, Admissions Period is December 2 – December 1, but readmissions are through December 31 For submissions July 31: Reporting Period is through Mar 31, Admissions Period is March 2 – Mar 1, but readmissions are through March 31 For submissions Oct 31: Reporting Period is through June 30, Admissions Period is June 1 – May 31, but readmissions are through June 30 For submissions Jan 31: Reporting Period is through Sept 30, Admissions Period is Sept 1 – August 31, but readmissions are through September 30
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	The readmission does **not** need to be at the same facility (or same type of facility) as the original discharge.
Continuous Enrollment Requirement	Include only those members who were continuously enrolled for 30 days after an inpatient discharge.
Item 1	Enter the total number of hospital admissions from the period 30 days prior to the start of the measurement period to 30 days prior to the end of the measurement period. The one exclusion is for any admissions for members who were not continuously enrolled with the MCE for 30 days after the date of discharge.
Item 2	Enter the subtotal of admissions in Item 1 from members that readmitted within 30 days from the previous discharge for any reason. This includes readmissions for related and unrelated reasons.
Item 3	Enter the subtotal of admissions in Item 1 from members that readmitted within 30 days from the previous discharge for a related diagnosis. If both admissions were grouped into APR-DRGs, then a related diagnosis is defined as the readmission case is mapped to the same APR-DRG as the original admission. The SOI levels between the two admissions do not need to be the same. If both cases were not grouped into APR-DRGs, then a related diagnosis means that the principal diagnosis on both cases is the same.
Item 4	This is a calculated field. Item 3 divided by Item 1.

Report Number	**0503**
Report Title	**Report 0503: Type of Emergency Department Utilization**
Purpose	To summarize utilization of emergency department services.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Yes, 90 days following the anchor date (last day) of the reporting period
Data Reported Each Submission	This is a rolling 12-month report. Data should be refreshed with each quarter's submission. The anchor date for each measure on this report is the last day of the 12-month reporting period. For submissions April 30: Reporting Period is Dec 31, Experience Period is Jan 1 – Dec 31 For submissions July 31: Reporting Period is Mar 31, Experience Period is Apr 1 – Mar 31 For submissions Oct 31: Reporting Period is June 30, Experience Period is July 1 – June 30 For submissions Jan 31: Reporting Period is Sept 30, Experience Period is Oct 1 – Sept 30
Lines of Business to Report	HHW, HIP (Basic, Plus and State Plan separate) and HCC
Specifications Used to Guide Definition	To define ED visits, use of the Diagnosis Codes Included in the Managed Care Health Plans' Emergency Department Autopay Lists Reviewed/Updated: July 1, 2023. Refer to Appendix E for the Managed Care Health Plan's Emergency Department Autopay Lists. Each MCE will use its own definition to define Emergent and Non-Emergent ED visits based on ICD-10 diagnosis code. Assign each ICD-10 code to only one category (emergent or non-emergent). Determine the age of the member each month and assign member months to each age category accordingly. This means that a member could have member months and ED visits in more than one item number on the report. For example, an HHW infant may have turned age one during the reporting period. Some months will be assigned to Item 1 while other months will be assigned to Item 2. Likewise, the ED visits should be distributed based upon the age when the member had the ED visit.
Continuous Enrollment Requirement	No
Column B	The age cohorts for each line of business are pre-defined in Items 1 through 19.
Column C	Enter the total member months for each age group during the full measurement period. Members may have their member months split across two rows if they age broke across two age cohort groups during the measurement period.

Column D	Enter the total ED visits adjudicated for the members represented on each row in Column C. The term adjudicated is used to signify that both paid and denied ED visits should be counted. The value sets in the Specifications section should be used to identify ED visits.
Column E	Enter from the total ED visits reported in Column D those that the MCE deemed to be emergent. Each MCE may use its internal definition for emergent ED visits.
Column F	Enter from the total ED visits reported in Column D those that the MCE deemed to be non-emergent. Each MCE may use its internal definition for non-emergent ED visits
Column G	This is a calculated field. On each row, it is the value in Column D divided by Column C, then multiplied by 1000.
Column H	This is a calculated field. On each row, it is the value in Column E divided by the value in Column D.
Column I	This is a calculated field. On each row, it is the value in Column F divided by the value in Column D.
Column J	This is a validation field. It checks to ensure that the sum of the percentages in Columns H and I equal 100%.

Report Number	**0504**
Report Title	**Report 0504: Frequency of Emergency Department Utilization**
Purpose	To summarize utilization of emergency department services by MCE members and to identify opportunities for participation in case or care management.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Yes, 90 days following the anchor date (last day) of the reporting period
Data Reported Each Submission	This is a rolling 12-month report. Data should be refreshed with each quarter's submission. The anchor date for each measure on this report is the last day of the 12-month reporting period. For submissions April 30: Reporting Period is Dec 31, Experience Period is Jan 1 – Dec 31 For submissions July 31: Reporting Period is Mar 31, Experience Period is Apr 1 – Mar 31 For submissions Oct 31: Reporting Period is June 30, Experience Period is July 1 – June 30 For submissions Jan 31: Reporting Period is Sept 30, Experience Period is Oct 1 – Sept 30
Lines of Business to Report	HHW, HIP (Basic, Plus and State Plan separate) and HCC
Specifications Used to Guide Definition	To define ED visits, use of the Diagnosis Codes Included on the Managed Care Health Plans' Emergency Department Autopay Lists Reviewed/Updated: July 1, 2023. Refer to Appendix E for the Managed Care Health Plan's Emergency Department Autopay Lists. Count each member in only one age cohort for a reporting period. Assign the member to the age cohort that represents their age as of the last day of the reporting period.
Continuous Enrollment Requirement	Yes, a minimum of 180 days continuous enrollment with the MCE during the 12-month reporting period
Column B	The age cohorts for each line of business are pre-defined in Items 1 through 19.
Column C	Enter the count of members that have had at least 180 days of continuous enrollment during the reporting period.
Column D	Enter the count of members in Column C that had no ED visits during the reporting period using the definition in the Specifications section.
Column E	Enter the count of members in Column C that had one ED visit during the reporting period using the definition in the Specifications section.
Column F	Enter the count of members in Column C that had two ED visits during the reporting period using the definition in the Specifications section.
Column G	Enter the count of members in Column C that had three to nine ED visits during the reporting period using the definition in the Specifications section.
Column H	Enter the count of members in Column C that had ten or more ED visits during the reporting period using the definition in the Specifications section.

Column I	This is a calculated field. On each row, it is the value in Column D divided by the value in Column C.
Column J	This is a calculated field. On each row, it is the value in Column E divided by the value in Column C.
Column K	This is a calculated field. On each row, it is the value in Column F divided by the value in Column C.
Column L	This is a calculated field. On each row, it is the value in Column G divided by the value in Column C.
Column M	This is a calculated field. On each row, it is the value in Column H divided by the value in Column C.
Column N	This is a calculated field. It checks to ensure that the sum of the percentages in Columns I through M equal 100%.

Report Number	**0505**
Report Title	**Report 0505: Pharmacy Utilization Report**
Purpose	To identify MCE members' pharmacy utilization and payments based on type of scripts.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Yes, 90 days following the anchor date (last day) of the reporting period
Data Reported Each Submission	This is a rolling 12-month report. Data should be refreshed with each quarter's submission. The anchor date for each measure on this report is the last day of the 12-month reporting period. For submissions April 30: Reporting Period is Dec 31, Experience Period is Jan 1 – Dec 31 For submissions July 31: Reporting Period is Mar 31, Experience Period is Apr 1 – Mar 31 For submissions Oct 31: Reporting Period is June 30, Experience Period is July 1 – June 30 For submissions Jan 31: Reporting Period is Sept 30, Experience Period is Oct 1 – Sept 30
Lines of Business to Report	HHW, HIP (Basic, Plus and State Plan separate) and HCC
Specifications Used to Guide Definition	Each MCE should use its own mapping of drugs to its Preferred Drug List to segregate the claims reported in Items 4/5 and Items 11/12.
Continuous Enrollment Requirement	No
Item 1	Enter the total member months for all members enrolled with the MCE during the reporting period by line of business.
Item 2	Among the members in Item 1, enter the total count of members with at least one paid pharmacy claim during the reporting period.
Item 3	Enter the total number of paid pharmacy claims in the reporting period. It is possible that a claim may have been adjudicated in one quarter but paid in a different quarter. Use the payment date, not the adjudication date, as the anchor date to count paid pharmacy claims.
Item 4	Among the paid claims in Item 3, enter the total paid claims that represent scripts on the MCE's Preferred Drug List.
Item 5	Among the paid claims in Item 3, enter the total paid claims that represent scripts not on the MCE's Preferred Drug List.
Item 6	Among the paid claims in Item 3, enter the total paid claims that represent scripts defined as generic drugs.
Item 7	Among the paid claims in Item 3, enter the total paid claims that represent scripts defined as non-generic drugs.
Item 8	This is a validation field. It checks that the sum of claims reported in Items 4 and 5 equal the value shown in Item 3.

Item 9	This is a validation field. It checks that the sum of claims reported in Items 6 and 7 equal the value shown in Item 3.
Item 10	Enter the total payments made by the MCE for the paid claims reported in Item 3.
Item 11	Enter the total payments made by the MCE for the paid claims reported in Item 4.
Item 12	Enter the total payments made by the MCE for the paid claims reported in Item 5.
Item 13	Enter the total payments made by the MCE for the paid claims reported in Item 6.
Item 14	Enter the total payments made by the MCE for the paid claims reported in Item 7.
Item 15	This is a validation field. It checks that the sum of expenditures reported in Items 11 and 12 equal the value shown in Item 10.
Item 16	This is a validation field. It checks that the sum of expenditures reported in Items 13 and 14 equal the value shown in Item 10.
Item 17	This is a calculated field. Item 3 divided by Item 1.
Item 18	This is a calculated field. Item 3 divided by Item 2.
Item 19	This is a calculated field. Item 10 divided by Item 2.
Item 20	This is a calculated field. Item 13 divided by Item 2.

Report Number	**0506**
Report Title	**Report 0506: Pharmacy Audit Report**
Purpose	To monitor compliance of participating pharmacies with the Pharmacy Benefit Manager (PBM) contract.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	No
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. The provider audits that are reported in the quarter are anchored by the audit close date. In other words, if an audit crosses two quarters, do not include in the information on two quarterly reports. Rather, wait and report all activity in the quarter that the audit was closed. For submissions April 30: Include audits closed in the period Jan 1 – Mar 31 For submissions July 31: Include audits closed in the period Apr 1 – June 30 For submissions Oct 31: Include audits closed in the period July 1 – Sept 30 For submissions Jan 31: Include audits closed in the period Oct 1 – Dec 31
Lines of Business to Report	All lines of business combined
Specifications Used to Guide Definition	If a provider was audited for more than one NDC, then list the provider NPI on multiple rows in the report. Each NPI/NDC combination should be reported on its own row.
Item 1	Enter the NPI of the provider being audited.
Item 2	Enter the name of the provider being audited.
Item 3	Enter the start date of the audit in mm/dd/yy format. The start date may be in a prior reporting period.
Item 4	Enter the end date of the audit in mm/dd/yy format. The end date must be in the current reporting period.
Item 5	Enter the number of claims reviewed for the specific NPI/NDC combination.
Item 6	Select from the drop-down list if this was a desk or field audit.
Item 7	Select from the drop-down list Yes or No if the MCE intends to recoup dollars from the provider.
Item 8	Enter the NDC number of the type of drug reviewed.
Item 9	Enter the name of the type of drug reviewed.

Report Number	**0507**
Report Title	**Report 0507: Service Utilization**
Purpose	To summarize utilization of ambulatory care services by MCE members.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Yes, 90 days following the anchor date (last day) of the reporting period
Data Reported Each Submission	This is a rolling 12-month report. Data should be refreshed with each quarter's submission. The anchor date for each measure on this report is the last day of the 12-month reporting period. For submissions April 30: Reporting Period is Dec 31, Experience Period is Jan 1 – Dec 31 For submissions July 31: Reporting Period is Mar 31, Experience Period is Apr 1 – Mar 31 For submissions Oct 31: Reporting Period is June 30, Experience Period is July 1 – June 30 For submissions Jan 31: Reporting Period is Sept 30, Experience Period is Oct 1 – Sept 30
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	To define ED claims in Item 1, use of the Diagnosis Codes Included on the Managed Care Health Plans' Emergency Department Autopay Lists Reviewed/Updated: July 1, 2023. Each MCE will use its own definition to define Emergent and Non-Emergent ED visits based on ICD-10 diagnosis code in Items 2 and 3, respectively. Assign each ICD-10 code to only one category (emergent or non-emergent). Refer to Appendix A for the mapping of CPT/HCPCS codes to include on each category for outpatient hospital claims in Items 6 through 10 and for professional claims in Items 13 through 33. Refer to Appendix E for the Managed Care Health Plan's Emergency Department Autopay Lists. Dental services to be reported in Item 11 include all services billed on the 837D dental claim form. Even if some dental services are billed on the outpatient hospital or professional claim form, do not include these in Item 11. Do not report any services paid on inpatient hospital claims or on the pharmacy claim form on this report.
Continuous Enrollment Requirement	No
Column B	The category of service to be reported is pre-populated in Column B.

Column C	Enter the unique count of members using each service in the reporting period in Items 2, 3, 6-10, 11 and 13-33. In Items 1, 5 and 12, these values are not the sum of the rows below it. Instead, enter the unique count of members that used services across Items 2 and 3 combined (in Item 1), across Items 6 through 10 combined (in Item 5), and across Items 13 through 33 combined (in Item 12). In Item 4, enter a description for each of the top 20 reasons for emergent ED visits.
Column D	Enter the number of paid claims for the members in Column C on each row. In Column D, Items 1, 5 and 12 are calculated fields because they should sum the total claims of the rows below it. The term 'claim' here means claim detail lines. It assumes that only claim detail lines with CPT/HCPCS codes will be reported in Items 6 through 10, 11 and 13-33 in Column D. Claim detail lines with only a revenue code and not a CPT/HCPCS will not be reported. For Items 2 and 3, claim detail lines with no CPT/HCPCS may be reported if the detail line conforms to the specifications in one of the HEDIS AMB measure value sets.
Column E	Enter the total expenditures for the claims reported in Column D on each row. In Column E, Items 1, 5 and 12 are calculated fields because they should sum the total claims of the rows below it. In Item 4, enter a description for each of the top 20 reasons for non-emergent ED visits.
Column F	These are calculated fields. On each row, it is the value in Column E divided by the value in Column C.
Column G	These are calculated fields. On each row, it is the value in Column E divided by the value in Column D.

Report Number	**0508**
Report Title	**Report 0508: Lead Testing**
Purpose	To assess the percentage of members who had a lead test during the reporting period using either MCE claims or evidence of tests submitted to the Indiana State Department of Health's (ISDH's) lead test database. Three separate measures are reported depending upon the age of the member. • Members who turned 1 year old during the measurement period • Members who turned 2 years old during the measurement period • The combined count of members who turned 3, 4, 5 or 6 years old during the measurement period
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Yes, 90 days following the anchor date (last day) of the reporting period
Data Reported Each Submission	This is a rolling 12-month report. Data should be refreshed with each quarter's submission. The anchor date for each measure on this report is the last day of the 12-month reporting period. For submissions April 30: Reporting Period is Dec 31, Experience Period is Jan 1 – Dec 31 For submissions July 31: Reporting Period is Mar 31, Experience Period is Apr 1 – Mar 31 For submissions Oct 31: Reporting Period is June 30, Experience Period is July 1 – June 30 For submissions Jan 31: Reporting Period is Sept 30, Experience Period is Oct 1 – Sept 30
Lines of Business to Report	HHW and HHC for the eligible age groups
Specifications Used to Guide Definition	To define lead tests from claims, use the definition applied in the Lead Screening in Children (LSC) measure in the currently active HEDIS technical specifications.
Continuous Enrollment Requirement	Utilize the continuous enrollment requirements as specified within the currently active HEDIS specifications.
Any Other Deviations from HEDIS Specification	The HEDIS specification for LSC only considers children who turned 2 years old during the measurement period. The OMPP is requesting information on this age group as well as children who turned 1 year old during the measurement period as a different study group. Also, the OMPP is requesting as a single study group information on children who turned 3, 4, 5 or 6 years old during the measurement period.
Item 1	Enter the number of members who turned age one during the measurement period for whom a lead test claim was found using the specification in the LSC measure.

Item 2	Enter the number of members who turned age one during the measurement period with evidence of a lead test, not through a claim but through the ISDH reports given to the MCE, using the specification in the LSC measure.
Item 3	Enter the number of members who turned age two during the measurement period for whom a lead test claim was found using the specification in the LSC measure.
Item 4	Enter the number of members who turned age two during the measurement period with evidence of a lead test, not through a claim but through the ISDH reports given to the MCE, using the specification in the LSC measure.
Item 5	Enter the number of members who turned age three, four, five or six during the measurement period for whom a lead test claim was found using the specification in the LSC measure.
Item 6	Enter the number of members who turned age three, four, five or six during the measurement period with evidence of a lead test, not through a claim but through the ISDH reports given to the MCE, using the specification in the LSC measure.
Item 7	Enter the number of members who turned age one during the measurement period.
Item 8	Enter the number of members who turned age two during the measurement period.
Item 9	Enter the number of members who turned age three, four, five or six during the measurement period.
Item 10	This is a calculated field. The sum of Items 1 and 2 divided by Item 7.
Item 11	This is a calculated field. The sum of Items 3 and 4 divided by Item 8.
Item 12	This is a calculated field. The sum of Items 5 and 6 divided by Item 9.

Report Number	**0510**
Report Title	**Report 0510: Utilization of Institutions for Mental Diseases (IMDs)**
Purpose	To monitor utilization of IMDs by members with SUD and SMI. To monitor the average lengths of stay in IMDs for SUD and SMI. To identify and monitor members in IMDs who are awaiting placement in State-Operated Facility (SOF).
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	No
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Include IMD utilization in the period Jan 1 – Mar 31 For submissions July 31: Include IMD utilization in the period Apr 1 – June 30 For submissions Oct 31: Include IMD utilization in the period July 1 – Sept 30 For submissions Jan 31: Include IMD utilization in the period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	Refer to the IMD Report Appendix for a list of current IMDs, diagnosis codes that define Serious Mental Illness (SMI), and diagnosis codes that define Substance Use Disorder (SUD) related conditions. To count days, include the day of admission and exclude the day of discharge. If a member is admitted and discharged on the same day, that should be reported as a 1 day stay. If a member is admitted one day and discharged the next day, that should also be reported as a 1 day stay.

Continuous Enrollment Requirement	No
Items 1, 8, 15, 15a, 15b, 22	Enter the total days for all members that had stays in IMDs during the reporting period.
Items 2, 9, 16, 16a, 16b, 23	Enter the total stays for all members that had stays in IMDs during the reporting period.
Items 3, 10, 17, 17a, 17b, 24	These are calculated fields. Total number of days divided by total number of stays.
Items 4, 11, 18, 18a, 18b, 25	For items 4, 18, 18a, and 18b, enter the total number of members whose stays were 30 days or less. For items 11 and 25, enter the total number of members whose stays were 15 days or less (in a calendar month).
Item 5, 12, 19, 19a, 19b, 26	For items 5, 19, 19a, and 19b, enter the total number of members whose stays exceeded 30 days but were less than 60 consecutive days. For items 12 and 26, enter the total number of members whose stays exceeded 15 days (in a calendar month) but were less than 30 consecutive days.
Items 6, 13, 20, 20a, 20b, 27	For items 6, 20, 20a, and 20b, enter the total number of members whose stays exceeded 60 consecutive days. For items 13 and 27, enter the total number of members whose stays exceeded 30 consecutive days.
Items 7, 14, 21, 28	Enter the total number of members who are awaiting placement in a state operated facility.
Item 29	Enter all members, by RID number, who are awaiting placement in a state operated facility.
Item 30	Select from the drop-down menu if the member's stay was in an SMI Inpatient, SUD Inpatient, SUD Residential, or Other type of IMD.

Item 31	Enter the length (in days) of the member's IMD stay.
Item 32	Select from the drop-down menu if the member is enrolled in HHW, HIP, or HCC.
Item 33	Enter the date the member was placed onto the SOF waiting list. You may obtain an exact or approximate date from the IMD or via a copy of the member's court commitment document. Use mm/dd/yy format.
Item 34	Enter the date the member was disenrolled from their MCE assignment, if applicable.

Report Number	**0511**
Report Title	**Report 0511: Translation and Interpretation Services Report**
Purpose	To monitor services which facilitate the participation and delivery of health care services for individuals requiring translation or interpretation services.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Not applicable
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Include translation/interpretation services in the period Jan 1 – Mar 31 For submissions July 31: Include translation/interpretation services in the period Apr 1 – June 30 For submissions Oct 31: Include translation/interpretation services in the period July 1 – Sept 30 For submissions Jan 31: Include translation/interpretation services in the period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Item 1	Enter the total number of tracked contacts to the language line during the reporting period.
Item 2	Enter the total number of requests for interpreter services made to the MCE during the reporting period. Interpreter services refer to requests from both a member and/or a provider to the MCE to assist the member with obtaining translation services. It will only be interpreter services the MCE coordinated at the request of the member or provider.
Item 3	Enter the number of interpretation services requested *and fulfilled* on the behalf of a member during the reporting period. Fulfillment of a service means the service was held and attended by all parties (the provider, the interpreter, and the member).

Item 4	This is a calculated field that shows the percentage of interpretation services completed during the reporting period (Item 2 divided by Item 3).

Report Number	**0512**
Report Title	**Report 0512: New Member Health Screener Report**
Purpose	To monitor the duration it takes for the MCE to complete a new member health needs screener.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lag?	Yes, 90-day lag from the end of the reporting quarter
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter after a 90-day lag. For submissions April 30: Include information on new members in the period Oct 1 – Dec 31 For submissions July 31: Include information on new members in the period Jan 1 – Mar 31 For submissions Oct 31: Include information on new members in the period Apr 1 – June 30 For submissions Jan 31: Include information on new members in the period July 1 – Sept 30
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	A new member is any member who has been away from the plan for 12 months and has not had a screener completed even if retro-added. The screener must be completed within 90 days of health plan notification or member eligibility, whichever is later. **NOTE:** When transferring files to Optum please submit all files on the 15th of each month. If there are resubmissions or corrections of files that have already been submitted, please wait until the 15th of the next month to resubmit those files.
Continuous Enrollment Requirement	No. Members are segmented on this report based on their enrollment duration.
Item 1	Enter the number of new **fully eligible** members enrolled with the MCE during the reporting period that require a screener to be completed.
Item 2	Enter the number of new members enrolled with the MCE during the reporting period that have since terminated within their first 90 days of enrollment.
Item 3	This is a calculated field. The formula is Item 1 minus Item 2.

Item 4	Enter the number of new members enrolled with the MCE during the reporting period determined to be unreachable. "Unreachable" is defined as a minimum of three outreach calls, made on different days at different times of the day, using the information provided to the MCE by OMPP but for which there is no response from the member.
Item 5	This is a calculated field. The formula is Item 3 minus Item 4.
Item 6	Enter the number of new members identified in Item #1 that were screened within their first 90 days of enrollment. **NOTE:** Be sure to include members in the total number for members screened who had a health needs screen completed even if the member is terminated within the 90 days. This will allow you to get credit for the time and effort the MCE put in to determine the member's needs.
Item 7	This is a calculated field of the percentage of newly enrolled MCE members, net of terminated members that have had a health screening assessment completed within 90 days. The formula is Item 6 divided by Item 3.
Item 8	This is a calculated field of the percentage of newly enrolled MCE members, net of terminated and unreachable members that have had a health screening assessment completed within 90 days. The formula is Item 6 divided by Item 5.

Report Number	**0513**
Report Title	**Report 0513: Comprehensive Health Assessment Tool**
Purpose	To identify the health needs of any member stratified into complex case management, care management or the Right Choices Program (RCP).
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lag?	Yes, 90-day lag from the end of the reporting quarter
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter after a 90-day lag. For submissions April 30: Include information on eligible members in the period Oct 1 – Dec 31 For submissions July 31: Include information on eligible members in the period Jan 1 – Mar 31 For submissions Oct 31: Include information on eligible members in the period Apr 1 – June 30 For submissions Jan 31: Include information on eligible members in the period July 1 – Sept 30

Lines of Business to Report	HCC only
Specifications Used to Guide Definition	MCEs are directed to identify members based on their internal stratification of enrollment in complex case management, care management and RCP.
Continuous Enrollment Requirement	No. Members are segmented on this report based on their enrollment duration.
Item 1	Enter the number of members enrolled with the MCE and stratified into complex case management during the reporting period that require a comprehensive health risk assessment to be completed.
Item 2	Enter the number of members enrolled with the MCE and stratified into care management during the reporting period that require a comprehensive health risk assessment to be completed.
Item 3	Enter the number of members enrolled with the MCE and stratified into the Right Choices Program during the reporting period that require a comprehensive health risk assessment to be completed.
Item 4	Enter the number of members enrolled with the MCE, and stratified in either complex case management, care management or the Right Choices Program during the reporting period, that have since terminated within their first 150 days of enrollment.
Item 5	This is a calculated field. The formula is the sum of Items 1, 2 and 3 minus Item 4.
Item 6	Enter the number of members identified in Item #5 that were screened within their first 150 days of enrollment.
Item 7	This is a calculated field of the percentage of enrolled MCE members who were stratified into complex case management, care management or RCP, net of terminated members, who had a comprehensive health risk assessment completed within 150 days. The formula is Item 6 divided by Item 5.

Report Number	**0514**
Report Title	**Report 0514: Care and Complex Case Management Report – Physical and Behavioral Health Conditions of Interest**
Purpose	To monitor the participation in and the effectiveness of the MCE's case management intervention activities.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lag?	No
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Include case/care management activities in the period Jan 1 – Mar 31 For submissions July 31: Include case/care management activities in the period Apr 1 – June 30 For submissions Oct 31: Include case/care management activities in the period July 1 – Sept 30 For submissions Jan 31: Include case/care management activities in the period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	For this report, case management refers to the definitions of Complex Case Management and Care Management established by NCQA. **Complex Case Management** – Complex case management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Since complex case management is considered an opt-out program, all eligible members have the right to participate or decline participation. The goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and

	development and implementation of a case management plan with performance goals, monitoring and follow-up. Distinguishing factors of complex case management: • Degree and complexity of illness or condition is typically severe • Level of management necessary is typically intensive • Amount of resources required for member to regain optimal health or improved functionality is typically extensive **Care Management** – Care management services include direct consumer contacts in order to assist members with the access to care for needed health or social services. This includes assistance with location specialty services, scheduling appointments, transportation needs and addressing social service needs. **Note that members in Care Management are not required to have a plan of care developed.** Each MCE is required to report on the following physical and health conditions: Asthma, Diabetes, Pregnancy, COPD, Coronary Artery Disease, Congestive Heart Failure, Chronic Kidney Disease, Sickle Cell Disease and the Right Choices Program. Each MCE is required to report on the following behavioral health conditions: Depression, ADHD, Autism/Pervasive Developmental Disorder, inpatient discharges from psychiatric hospital, Bipolar Disorder, SUD and Right Choices Program. The MCE should distinguish between programs for each condition of interest in a manner that is reflective of the plan's measurement objectives. This may either be through a disease condition, risk stratification, or population-based methodology. In addition to the OMPP required conditions of interest, the MCE should enumerate and report separately on MCE-specific programs. If the MCE does this, write out the program name, **no abbreviations.**

Continuous Enrollment Requirement	No
Header Rows	At the top of the Physical Health and Behavioral Health sections of the report, the MCE should enter information about the total unique members enrolled across <u>all</u> conditions of interest within the major category of interest. This means that: • The values reported at the top are the unique counts of members within each line of business. • The values are also the unique count for members in <u>either</u> complex case or care management. • One value in the line of business represents unique members across the physical health conditions of interest. A different value represents unique members across the behavioral health conditions of interest. The same member could appear in the top line of both portions of the report. Below the top lines, information should be reported by each condition of interest for each line of business. **It is assumed that some participating members may be enrolled in complex case or care management for more than one condition of interest. Therefore, the information shown for each condition of interest will likely not be mutually exclusive to information reported for another condition of interest.** <u>Example #1:</u> A member is identified for complex case management for asthma and care management for diabetes. He should be counted in the identified totals in the asthma row AND the diabetes row. However, in the unique members count at the top of the report for physical health conditions, he should be counted only once. <u>Example #2:</u> A member is identified for complex case management for SUD and care management for diabetes. She should be counted in the identified totals in the SUD row AND the diabetes row. She is counted in the unique members count at the top of the report for physical health conditions AND in the unique members count at the top of the report for behavioral health conditions.
Item 1	Utilize the OMPP required conditions of interest provided on the report or provide the program title of the MCE-specific program.
Item 2	The values are pre-populated to indicate the rows for each specific line of business.
Item 3	Enter the total number of members that were identified as potential candidates for the care management and complex case management programs during the reporting period by any means

	utilized by the MCE. For "All Conditions of Interest", count each member only once. Members may be counted in more than one of the individual disease states listed.
Item 4	Of the total members entered in Item #3, enter the total number of members that were identified as potential candidates for the care management and complex case management programs specifically through either the Health Needs Screening (HNS) tool or the Notification of Pregnancy (NOP) report. For "All Conditions of Interest", count each member only once. Members may be counted in more than one of the individual disease states listed.
Item 5	Enter the total number of members who have been invited to participate in care or complex case management by the MCE and who either refused or chose to opt out. This may include members who were identified for invitation to participate in a prior reporting period. **This does not include members who were automatically assigned to either care or complex case management by the MCE without having been contacted by the MCE.**
Item 6	Enter the total number of members that were enrolled in the program at any time during the reporting period regardless of when they were ever enrolled. This number does not include the number of members who opted out of the program. "Active Enrollment" means the member has had at least one live verbal conversation with an MCE case manager and has agreed to participate in the program. **The one exception to this is the Condition of Interest for Inpatient Discharges from a Psychiatric Hospital report.** OMPP requires that all members discharged from a psychiatric hospital be enrolled in case management for 90 days post-discharge, all members in this Condition of Interest are classified as Active.
Item 7	Among the members identified in Item #6, report the number of days that each member was participating during the reporting period. Sum all of the days among all active ever enrolled participants.
Item 8	Enter the total number of live verbal contacts directly between the member and the MCE case manager in the reporting period. The total contacts do not include non-verbal contacts, messages left for members, IVRs, or communications with the member's providers. Sum all of the phone contacts among all active, ever enrolled participants.
Item 9	Enter the total number of contacts classified as provider-focused in the reporting period. Sum all of the contacts among all active, ever enrolled participants.

	Provider-Focused Contacts include: 1) Materials mailed or emailed 2) Contact is defined as a telephone call, one to one conversation, email, fax, texting, or telephone call with an entity involved in a member's identified medical needs. Examples: o Contact with the member's primary care provider o Contact with the member's specialist(s) o Contact with the member's pharmacy o Contact with the member's rehabilitation staff o Contact with the member's home health or visiting nurse staff o Contact with the member's hospice staff o Contact with the member's primary care giver o Contact with the member's behavioral health provider o Contact with the designated family member
Item 10	The total contacts with or on behalf of the member. Sum the contacts in Items 8 and 9 together.
Item 11	Enter the total number of members who were disenrolled during the reporting period. This should include members disenrolled for various reasons including successful completion of the member's treatment plan, transition to a higher functioning program, or due to unsuccessful contact attempts which warrant transition of staffing resources. The MCE should maintain the capacity to drill down on disenrollment statistics upon request.
Item 12	Enter the subset of the total number of members reported in Item #6 who were enrolled in complex case or care management on the last day of the reporting period.
Item 13	Enter the total number of complex case and care managers reflected as a full-time equivalent figure. If case managers at the MCE also perform other UM functions, assign their time to performing case/care management based either on total hours per week spent on case/care management or based on the portion of their caseload that has case/care management members. Enter as a number taken to one decimal point (e.g., 5.7 FTEs).
Item 14	This is a calculated field. The formula is Total Participation Days in the Reporting Period by Active Ever Enrolled divided by The Total Full-Time Equivalent Case Managers further divided by 90 days Or [Item 7 divided by Item 13 divided by 90]
Item 15	This is a calculated field. The formula is Total Participation Days in the Reporting Period by Active Ever Enrolled divided by

	The Total Active Ever Enrolled in the Reporting Period Or [Item 7 divided by Item 6]
Item 16	This is a calculated field. The formula is Total Live Verbal Contacts in Reporting Period by Active Ever Enrolled divided by The Total Active Ever Enrolled in the Reporting Period further divided by 3 months Or [Item 8 divided by Item 6 divided by 3]

Report Number	**0515**
Report Title	**Report 0515: Disease Management Report – Physical and Behavioral Health Conditions of Interest**
Purpose	To monitor the participation in and the effectiveness of the MCE's disease management intervention activities.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lag?	No
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Include disease management activities in the period Jan 1 – Mar 31 For submissions July 31: Include disease management activities in the period Apr 1 – June 30 For submissions Oct 31: Include disease management activities in the period July 1 – Sept 30 For submissions Jan 31: Include disease management activities in the period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	Disease management refers to the definition established by NCQA: Disease management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease management supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. It continuously evaluates clinical, humanistic and economic outcomes with the goal of improving overall health. The MCE should distinguish between programs for each condition of interest in a manner that is reflective of the plan's measurement objectives. This may either be through a disease condition, risk stratification, or population-based methodology. In addition to the OMPP required conditions of interest, the MCE may enumerate and report separately on MCE-specific programs.
Continuous Enrollment Requirement	No

Header Rows	At the top of the Physical Health and Behavioral Health sections of the report, the MCE should enter information about the total unique members enrolled across <u>all</u> conditions of interest within the major category of interest. This means that: • The values reported at the top are the unique counts of members within each line of business. • One value in the line of business represents unique members across the physical health conditions of interest. A different value represents unique members across the behavioral health conditions of interest. The same member could appear in the top line of both portions of the report. Below this, information should be reported by each condition of interest. It is assumed that some participating members may be enrolled in disease management for more than one condition of interest. Therefore, the information shown for each condition of interest may not be mutually exclusive to information reported for another condition of interest.
Item 1	Utilize the OMPP required conditions of interest provided on the report, or provide the program title of the MCE-specific program.
Item 2	The values are pre-populated to indicate the rows for each specific line of business.
Item 3	Enter the total number of members that were identified as potential candidates for the program during the reporting period by any means utilized by the MCE.
Item 4	Enter the total number of members that were enrolled into the program during the reporting period. This number does not include the number of members who opted out of the program.
Item 5	Enter the subset of the total number of members reported in Item #4 who were enrolled in disease management on the last day of the reporting period.
Item 6	Among the members identified in Item #4, report the number of contacts with the member. The total contacts may include phone calls with the member, phone calls with the member's providers, other phone outreach on behalf of the member, IVRs, or mailings to the member directly related to their condition of interest. Sum all of the contacts among all active ever enrolled participants.
Item 7	This is a calculated field. The formula is Total Contacts in Reporting Period by Ever Enrolled divided by The Total Ever Enrolled in the Reporting Period further divided by 3 months Or [Item 6 divided by Item 4]

Report Number	**0601**
Report Title	**Report 0601: Prior Authorization Report (Pre-Service)**
Purpose	To track the number, determination rate and turnaround times for pre-service authorization requests made to the MCE.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Not applicable
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Include authorizations submitted/adjudicated in the period Jan 1 – Mar 31 For submissions July 31: Include authorizations submitted/adjudicated in the period Apr 1 – June 30 For submissions Oct 31: Include authorizations submitted/adjudicated in the period July 1 – Sept 30 For submissions Jan 31: Include authorizations submitted/adjudicated in the period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	Refer to Appendix B for the mapping of services to authorization categories on this report. The authorization requests may be defined by claim type, provider type, provider specialty, APR-DRG and/or CPT or HCPCS. An authorization may be for one unit of service or multiple units of service. An initial authorization request with applicable MCE decision is counted only once. Any additional decision(s) by the MCE to increase the duration or scope of service for the same member/service are counted as separate authorization requests on this report.
Continuous Enrollment Requirement	No
Item 1	Enter the number of service authorization requests submitted by providers during the reporting period.
Item 2	Enter the number of service authorization requests adjudicated (a final decision made) by the MCE during the reporting period. The authorizations adjudicated may not be all the same authorization requests received due to carry-over from a prior period.
Item 3	Enter the number of service authorization requests adjudicated in Item 2 which were deemed to be non-expedited.

Item 4	Enter the number of service authorization requests adjudicated in Item 2 which were deemed to be expedited.
Item 5	This is a validation field. It ensures that the sum of the values in Items 3 and 4 equals the value in Item 2.
Item 6	Enter the number of non-expedited authorization requests in Item 3 that were adjudicated timely (that is, within 5 business days of receipt).
Item 7	Enter the number of expedited authorization requests in Item 4 that were adjudicated timely (that is, within 48 hours of receipt).
Item 8	This is a calculated field. It is the sum of the values in Items 6 and 7 divided by the value in Item 2.
Item 9	Calculate the total number of calendar days between the receipt date from the provider for the authorization request and the MCE decision date by first translating the calendar dates to its Julian date, then subtracting the decision date from receipt date. Then sum all days from all authorizations adjudicated in the reporting period.
Item 10	This is a calculated field. It is Item 9 divided by Item 2.
Item 11	Enter the total number of authorizations in Item 2 that resulted in a fully approved service.
Item 12	Enter the total number of authorizations in Item 2 that resulted in a fully denied service due to medical necessity
Item 13	Enter the total number of authorizations in Item 2 that resulted in a fully denied service due to administrative issues.
Item 14	Enter the total number of authorizations in Item 2 that resulted in a partially denied service or an approval that was made that was adjusted from the original request.
Item 15	This is a validation field. It ensures that the sum of the values in Items 11, 12,13 and 14 equals the value in Item 2.
Item 16	This is a calculated field. Item 11 divided by Item 2.
Item 17	This is a calculated field. Item 12 divided by Item 2
Item 18	This is a calculated field. Item 13 divided by Item 2
Item 19	This is a calculated field. Item 14 divided by item 2
Calculation Fields	The fields below Item 19 are calculation fields. The values pull data from Reports 0601, 0602, 0603 and 0604 in order to compute a weighted rate of total authorizations adjudicated timely across pre-service, concurrent review, retrospective and pharmacy.

Report Number	**0602**
Report Title	**Report 0602: Prior Authorization Report (Concurrent)**
Purpose	To track the number, determination rate and turnaround times for concurrent review authorization requests made to the MCE.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Not applicable
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Include authorizations submitted/adjudicated in the period Jan 1 – Mar 31 For submissions July 31: Include authorizations submitted/adjudicated in the period Apr 1 – June 30 For submissions Oct 31: Include authorizations submitted/adjudicated in the period July 1 – Sept 30 For submissions Jan 31: Include authorizations submitted/adjudicated in the period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	Refer to Appendix B for the mapping of services to authorization categories on this report. The authorization requests may be defined by claim type, provider type, provider specialty, APR-DRG and/or CPT or HCPCS. An authorization may be for one unit of service or multiple units of service. An initial authorization request with applicable MCE decision is counted only once. Any additional decision(s) by the MCE to increase the duration or scope of service for the same member/service are counted as separate authorization requests on this report.
Continuous Enrollment Requirement	No
Item 1	Enter the number of service authorization requests submitted by providers during the reporting period.
Item 2	Enter the number of service authorization requests adjudicated (a final decision made) by the MCE during the reporting period. The authorizations adjudicated may not be all the same authorization requests received due to carry-over from a prior period.
Item 3	Enter the number of concurrent review authorization requests in Item 2 that were adjudicated timely (that is, within 1 business day after receiving all necessary information to make a decision).

Item 4	This is a calculated field. Item 3 divided by Item 2.
Item 5	Calculate the total number of calendar days between the receipt date from the provider for the authorization request and the MCE decision date by first translating the calendar dates to its Julian date, then subtracting the decision date from receipt date. Then sum all days from all authorizations adjudicated in the reporting period.
Item 6	This is a calculated field. It is Item 5 divided by Item 2.
Item 7	Enter the total number of authorizations in Item 2 that resulted in a fully approved service.
Item 8	Enter the total number of authorizations in Item 2 that resulted in a fully denied service for medical necessity
Item 9	Enter the total number of authorizations in Item 2 that resulted in a fully denied service for administrative issues
Item 10	Enter the total number of authorizations in Item 2 that resulted in a partially denied service or an approval that was made that was adjusted from the original request.
Item 11	This is a validation field. It ensures that the sum of the values in Items 7, 8,9 and10equals the value in Item 2.
Item 12	This is a calculated field. Item 7 divided by Item 2.
Item 13	This is a calculated field. Item 8 divided by Item 2.
Item 14	This is a calculated field. Item 9 divided by Item 2.
Item 15	This is a calculated field. Item 10 divided by item 2

Report Number	**0603**
Report Title	**Report 0603: Prior Authorization Report (Retrospective)**
Purpose	To track the number, determination rate and turnaround times for retrospective authorization requests made to the MCE.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Not applicable
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Include authorizations submitted/adjudicated in the period Jan 1 – Mar 31 For submissions July 31: Include authorizations submitted/adjudicated in the period Apr 1 – June 30 For submissions Oct 31: Include authorizations submitted/adjudicated in the period July 1 – Sept 30 For submissions Jan 31: Include authorizations submitted/adjudicated in the period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	Refer to Appendix B for the mapping of services to authorization categories on this report. The authorization requests may be defined by claim type, provider type, provider specialty, APR-DRG and/or CPT or HCPCS. An authorization may be for one unit of service or multiple units of service. An initial authorization request with applicable MCE decision is counted only once. Any additional decision(s) by the MCE to increase the duration or scope of service for the same member/service are counted as separate authorization requests on this report.
Continuous Enrollment Requirement	No
Item 1	Enter the number of service authorization requests submitted by providers during the reporting period.
Item 2	Enter the number of service authorization requests adjudicated (a final decision made) by the MCE during the reporting period. The authorizations adjudicated may not be all the same authorization requests received due to carry-over from a prior period.
Item 3	Enter the number of retrospective review authorization requests in Item 2 that were adjudicated timely (that is, within 30 calendar days of receipt).

Item 4	This is a calculated field. Item 3 divided by Item 2.
Item 5	Calculate the total number of calendar days between the receipt date from the provider for the authorization request and the MCE decision date by first translating the calendar dates to its Julian date, then subtracting the decision date from receipt date. Then sum all days from all authorizations adjudicated in the reporting period.
Item 6	This is a calculated field. It is Item 5 divided by Item 2.
Item 7	Enter the total number of authorizations in Item 2 that resulted in a fully approved service.
Item 8	Enter the total number of authorizations in Item 2 that resulted in a fully denied service for medical necessity
Item 9	Enter the total number of authorizations in Item 2 that resulted in a fully denied service for administrative issues.
Item 10	Enter the total number of authorizations in Item 2 that resulted in a partially denied service or an approval that was made that was adjusted from the original request.
Item 11	This is a validation field. It ensures that the sum of the values in Items 7, 8,9 and 10 equals the value in Item 2.
Item 12	This is a calculated field. Item 7 divided by Item 2.
Item 13	This is a calculated field. Item 8 divided by Item 2.
Item 14	This is a calculated field. Item 9 divided by Item 2.
Item 15	This is a calculated field. Item 10 divided by Item 2.

Report Number	**0604**
Report Title	**Report 0604: Prior Authorization Report (Pharmacy Only)**
Purpose	To track the number, determination rate and turnaround times for pharmacy authorization requests made to the MCE.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Not applicable
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Include authorizations submitted/adjudicated in the period Jan 1 – Mar 31 For submissions July 31: Include authorizations submitted/adjudicated in the period Apr 1 – June 30 For submissions Oct 31: Include authorizations submitted/adjudicated in the period July 1 – Sept 30 For submissions Jan 31: Include authorizations submitted/adjudicated in the period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	Include only those authorization requests made to the MCE's pharmacy benefit manager or to the MCE's internal pharmacy authorization unit separate from the medical unit.
Continuous Enrollment Requirement	No
Item 1	Enter the number of service authorization requests submitted by providers during the reporting period.
Item 2	Enter the number of service authorization requests adjudicated (a final decision made) by the MCE during the reporting period. The authorizations adjudicated may not be all the same authorization requests received due to carry-over from a prior period.
Item 3	Enter the number of pharmacy authorization requests in Item 2 that were adjudicated timely (that is, within 24 hours of receipt).
Item 4	This is a calculated field. Item 3 divided by Item 2.
Item 5	Calculate the total number of calendar days between the receipt date from the provider for the authorization request and the MCE decision date by first translating the calendar dates to its Julian date, then subtracting the decision date from receipt date. Then sum all days from all authorizations adjudicated in the reporting period.
Item 6	This is a calculated field. It is Item 5 divided by Item 2.

Item 7	Enter the total number of authorizations in Item 2 that resulted in a fully approved service.
Item 8	Enter the total number of authorizations in Item 2 that resulted in a fully denied service for medical necessity
Item 9	Enter the total number of authorizations in Item 2 that resulted in a fully denied service for administrative issues
Item 10	This is a validation field. It ensures that the sum of the values in Items 7,8and 9equals the value in Item 2.
Item 11	This is a calculated field. Item 7 divided by Item 2.
Item 12	This is a calculated field. Item 8 divided by Item 2.
Item 13	This is a calculated field. Item 9 divided by Item 2.

Report Number	**0605**
Report Title	**Report 0605: Prior Authorization Report by Therapeutic Class**
Purpose	To track the number and determination rate for pharmacy authorization requests made to the MCE by therapeutic class.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Not applicable
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Include authorizations submitted/adjudicated in the period Jan 1 – Mar 31 For submissions July 31: Include authorizations submitted/adjudicated in the period Apr 1 – June 30 For submissions Oct 31: Include authorizations submitted/adjudicated in the period July 1 – Sept 30 For submissions Jan 31: Include authorizations submitted/adjudicated in the period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	Include only those authorization requests included in Report 0604 for the reporting period.
Continuous Enrollment Requirement	No
Items 1 through 11	Distribute the pharmacy authorization requests adjudicated during the reporting period included in Report 0604, Item 2. First distribute these authorizations by therapeutic class. The MCE will identify the top 10 therapeutic classes based on volume of requests. Report the top 10 therapeutic classes in descending order in Items 1 through 10. All other authorization requests are included in Item 11 under "All Other Therapeutic Classes". If the MCE uses Medispan, report the GPI-4 in the Therapeutic Class Number column. If the MCE uses First Databank, report the GSN in the Therapeutic Class Number column. Enter the therapeutic class name given depending upon the classification system used in Column C.

	Then, distribute the authorization in each of the top 10 categories between those authorizations that were approved by the MCE and those that were denied. Repeat this for the row "All Other Therapeutic Classes".
Item 12	These are validation fields. It ensures that the sum of authorizations approved in Column D, Items 1 through 11 equals the total approved as included in Report 0604, Item 7. It ensures that the sum of authorizations denied in Column E, Items 1 through 11 equals the total denied as included in Report 0604, Items 8 and 9. It ensures that the sum of authorizations adjudicated in Column F, Items 1 through 11 equals the total adjudicated as included in Report 0604, Item 2.

Report Number	**0701**
Report Title	**Report 0701: Provider Helpline Call Reasons**
Purpose	To monitor the providers' concerns being handled by the MCE's Provider Helpline.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lag?	Not applicable
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Include provider helpline calls in the period Jan 1 – Mar 31 For submissions July 31: Include provider helpline calls in the period Apr 1 – June 30 For submissions Oct 31: Include provider helpline calls in the period July 1 – Sept 30 For submissions Jan 31: Include provider helpline calls in the period Oct 1 – Dec 31
Lines of Business to Report	HIP only, all sub-programs combined
Specifications Used to Guide Definition	Enter the total number of provider calls received by the MCE to the Provider Helpline ACD call queue during open hours of operation, including calls in which the provider calls directly into the Provider Helpline, transfers into the Provider Helpline or selects a provider services option placing the provider into the call queue. This includes provider calls to external call centers for dental, vision, and transportation services.
Items 1-10	Enter the top 10 topic(s) of HIP concerns for the provider calls. Enter the number of callers for each topic. The total of concerns may be greater than the number of callers.

Report Number	**0702**
Report Title	**Report 0702: Nurse Line Call Reasons**
Purpose	To monitor the members calling the Nurse Call Line prior to going to the Emergency Department .
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lag?	Not applicable
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Include Nurse Call Line calls in the period Jan 1 – Mar 31 For submissions July 31: Include Nurse Call Line calls in the period Apr 1 – June 30 For submissions Oct 31: Include Nurse Call Line calls in the period July 1 – Sept 30 For submissions Jan 31: Include Nurse Call Line calls in the period Oct 1 – Dec 31
Lines of Business to Report	HIP Basic, HIP Plus, HIP State Plan separately
Specifications Used to Guide Definition	The MCE must track member calls to the Nurse Call Line for all HIP members (HIP Plus, HIP Basic, and HIP State Plan) and the time of day the calls were received. If the member's RID or other information to identify the sub-program within HIP that the member is enrolled is not tracked when the call is placed to the Nurse Call Line, then default these calls to Items 1 through 3 on the report in the HIP Basic section.
Items 1, 4, 7	Report the total number of HIP member calls received by the Nurse Call Line, all times of the day combined. Report information for HIP Basic members in Item 1, for HIP Plus members in Item 4, and for HIP State Plan members in Item 7. This includes calls in which the member calls directly into the Nurse Call Line, transfers into the Nurse Call Line, or selects a member services option placing the member into the automatic call distribution call queue. This does not apply to other call centers (e.g., member helpline or pharmacy).
Items 2, 5, 8	Report the top 10 topics of concern for all HIP member calls from 8:00 am to 5:00 pm. Enter the number of callers for each topic in the columns. Report information for HIP Basic members in Item 2, for HIP Plus members in Item 5, and for HIP State Plan members in Item 8. The total of concerns may be greater than the number of callers.
Items 3, 6, 9	Report the top 10 topics of concern for all HIP member calls all other times of the day. Enter the number of callers for each topic in the columns. Report information for HIP Basic members in Item 3, for HIP Plus members in Item 6, and for HIP State Plan members in Item 9. The total of concerns may be greater than the number of callers.

Report Number	**0703**
Report Title	**Report 0703: Preventive Exam (Rollover Related)**
Purpose	To identify HIP members who received a preventive exam applicable to rollover.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Yes, 90 days following the last day of the reporting period
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Reporting Period is Oct 1 – Dec 31 For submissions July 31: Reporting Period is Jan 1 – March 31 For submissions Oct 31: Reporting Period is Apr 1 – Jun 30 For submissions Jan 31: Reporting Period is July 1 – Sep 30
Lines of Business to Report	HIP Basic, HIP Plus, HIP State Plan separately
Specifications Used to Guide Definition	Refer to the published list of Preventive Care Services Excluded from Copayment for Healthy Indiana Plan and Presumptive Eligibility – Adult on the IHCP Provider Code Set Tables website.
Continuous Enrollment Requirement	No
Item 1	Enter the number of HIP members who earned a premium reduction during the reporting period, by receiving the first preventative care service of their benefit year during the reporting period, regardless of whether the premium reduction occurs during reporting period or in the future, from completing their first preventive care visit. From the total in column F, distribute the number of HIP members into each subpopulation in columns G-AF.
Item 2	Enter the number of HIP members who received at least one preventive care service during the reporting period. From the total in column F, distribute the number of HIP members into each subpopulation in columns G-AF.
Item 3	Enter the total number of members enrolled in the HIP sub-program with the MCE as of the last day of the reporting period.
Item 4	This is a calculated field showing the percentage of members who received a preventive exam excluding counseling visits. Item 3 divided by Item 4.

Report Number	**0704**
Report Title	**Report 0704: Medically Frail Member Identification**
Purpose	To identify the number of members who are medically frail and enrolled in either HIP State Plan Plus or HIP State Plan Basic.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	No
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Include Members identified in the period Jan 1 – Mar 31 For submissions July 31: Include Members identified in the period Apr 1 – June 30 For submissions Oct 31: Include Members identified in the period July 1 – Sept 30 For submissions Jan 31: Include Members identified in the period Oct 1 – Dec 31
Lines of Business to Report	HIP only, all sub-programs combined
Specifications Used to Guide Definition	**Please note items 1+ 2 + 4 should equal items 5 + 6.** If members are not counted in the HIP State Plan Plus or HIP State Plan Basic their RID number should be reported in the comments section along with a reason for non-enrollment.
Continuous Enrollment Requirement	No
Item 1	Enter the number of members during the reporting period who were identified via the review of claims data or state records and verified as medically frail.
Item 2	Enter the number of members during the reporting period who were identified via the completion of a health needs screener or comprehensive health assessment and verified as medically frail.
Item 3	Enter the number of members during the reporting period who self-identified as medically frail.
Item 4	Enter the number of members identified in Item #3 during the reporting period who were verified as medically frail within 30 days of self-attestation.
Item 5	Enter the number of members identified in Items #1, #2, and #4 who enrolled in HIP State Plan Plus.
Item 6	Enter the number of members in Items #1, #2, and #4 who enrolled in HIP State Plan Basic.

Report Number	**0705**
Report Title	**Report 0705: ED Co-Payment Report**
Purpose	To monitor members' co-payment expenditures by income levels.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	No
Data Reported Each Submission	This is a point-in-time as well as a year-to-date report. For the point-in-time (Quarter) column, data is reported for the activity in a single quarter after a 90-day lag. For submissions April 30: Include ED utilization in the period Oct 1 – Dec 31 For submissions July 31: Include ED utilization in the period Jan 1 – Mar 31 For submissions Oct 31: Include ED utilization in the period Apr 1 – June 30 For submissions Jan 31: Include ED utilization in the period July 1 – Sept 30 For the YTD column, refresh the data to reflect activity for year-to-date. For submissions April 30: Include ED utilization in the period Jan 1 – Dec 31 For submissions July 31: Include ED utilization in the period Jan 1 – Mar 30 For submissions Oct 31: Include ED utilization in the period Jan 1 – June 30 For submissions Jan 31: Include ED utilization in the period Jan 1 – Sept 30
Lines of Business to Report	HIP only, all sub-programs combined
Specifications Used to Guide Definition	Use the same definition for ER visits as was used in Report 0507. This is the definition applied in the Diagnosis Codes Included on the Managed Care Health Plans' Emergency Department Autopay Lists Reviewed/Updated: July 1, 2023. Refer to Appendix E for the Managed Care Health Plan's Emergency Department Autopay Lists

Items 1-6	Indicate the number of members who had an ED visit during the reporting period, and the resulting ER co-payment applied to that encounter. Members are separated into those that paid an $8 co-payment per visit (Items 1, 2, 3) or those that were waived a co-payment (Items 4, 5, 6). For the populations listed with waived co-pay, this indicates that the visit was considered to meet the prudent layperson definition of emergency and the co-pay was waived or reimbursed. Co-pays are also waived for members in specific populations including Native Americans and pregnant women.

Report Number	**0706**
Report Title	**Report 0706: POWER Account Contribution - Employer & Non-Profit Organization Participation Summary**
Purpose	To monitor the participation of employers' and non-profit organizations' contributions towards the POWER account on behalf of HIP members.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lag?	Not applicable
Data Reported Each Submission	Data is reported for the activity in a single quarter in the Quarterly column. For submissions April 30: Include employers and non-profits in the period Jan 1 – Mar 31 For submissions July 31: Include employers and non-profits in the period Apr 1 – June 30 For submissions Oct 31: Include employers and non-profits in the period July 1 – Sept 30 For submissions Jan 31: Include employers and non-profits in the period Oct 1 – Dec 31
Lines of Business to Report	HIP only, all sub-programs combined
Specifications Used to Guide Definition	An employer's contribution must not exceed 100% of the member's annual contribution amount.
Continuous Enrollment Requirement	Not applicable
Item 1	In Columns C-E, enter the total number of members on whose behalf a third-party made a contribution during each month of the reporting period. In Column G, enter the total number of third parties that made member contributions on behalf of a member during the reporting period. In Column H, enter the total dollar amount that third parties contributed on behalf of members during the reporting period. In Column I, enter the average dollar amount of employer contributions made on behalf members during the reporting period (Column H divided by Column F).
Items 2-10	From Item 1 Columns C-E, distribute these members based on their Federal Poverty Level and aid categories according to the following categories: • For members with incomes <22% FPL, enter the total in Item 2. • For member with incomes between 23% FPL and 50% FPL, enter the total in Item 3. • For members with incomes between 51% FPL and 75% FPL, enter the total in Item 4. • For members with incomes between 76% FPL and 100% FPL, enter the total in Item 5. • For members with incomes between 101% FPL and 138% FPL, enter the total in Item 6. • For members designated as Low-Income Parent & Caretaker, enter the total in Item 7.

	• For members determined eligible for Temporary Medical Assistance (TMA), enter the total in Item 8. • For members who are pregnant, enter the total in Item 9. • For members who are designated as Newly Eligible for Medicaid, enter the total in Item 10..

Report Number	**0707**
Report Title	**Report 0707: Aggregate POWER Account Contribution Detail**
Purpose	To monitor the POWER account contribution activity.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lag?	Not applicable
Data Reported Each Submission	Data is reported for the activity in a single quarter in the Quarterly column. For submissions April 30: Include contributions in the period Jan 1 – Mar 31 For submissions July 31: Include contributions in the period Apr 1 – June 30 For submissions Oct 31: Include contributions in the period July 1 – Sept 30 For submissions Jan 31: Include contributions in the period Oct 1 – Dec 31
Lines of Business to Report	HIP only, all sub-programs combined
Specifications Used to Guide Definition	The MCE must deposit checks no later than 10 calendar days after receipt.
Continuous Enrollment Requirement	Not applicable
Items 1-6	For columns E-G, enter the number of initial member contributions received by the MCE during each month of the reporting period by FPL in Items 2 through 6. The initial member contribution is the first contribution due after an individual is determined to be conditionally eligible for HIP and is required before coverage under the MCE begins. **Fast track payments are considered initial contributions.** For columns I-K, enter the number of subsequent member contributions received by the MCE during each month of the reporting period by FPL in Items 2 through 6. The subsequent member contribution is any contribution after the first contribution. For columns E-G, sum the members under all FPLs in Items 2 through 6 to obtain the total in Item 1. For columns I-K, sum the members under all FPLs in Items 2 through 6 to obtain the total in Item 1.
Item 7-10	For columns E-G, enter the number of initial member contributions received by the MCE during each month of the reporting by aid categories in Items 7-10. For columns I-K, enter the number of subsequent member contributions received by the MCE during each month of the reporting by aid categories in Items 7-10.

Item 11	Enter the total number of initial member contributions received in previous reporting periods that were pending as of the last day of the previous reporting period.
Item 12	Enter the total number of initial member contributions processed during the reporting period.
Item 13	Enter the average length of time in calendar days to process initial member contributions in the reporting period. To do this, • Identify the Julian date of the lockbox deposit of the initial member contribution. • Then subtract the Julian date the MCE notified DXC that the member's payment has been processed. The average days, therefore, is the total number of days divided by total number of payments processed.
Item 14	Enter the total number of initial contributions that are pending deposit as of the last day of the reporting period.

Report Number	**0708**
Report Title	**Report 0708: Aggregate POWER Account Contribution Refund Detail**
Purpose	To monitor the number and amounts of power account contributions that result in a refund.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lag?	Not applicable
Data Reported Each Submission	Data is reported for the activity in a single quarter in the Quarterly column. For submissions April 30: Include contribution refunds in the period Jan 1 – Mar 31 For submissions July 31: Include contribution refunds in the period Apr 1 – June 30 For submissions Oct 31: Include contribution refunds in the period July 1 – Sept 30 For submissions Jan 31: Include contribution refunds in the period Oct 1 – Dec 31
Lines of Business to Report	HIP only, all sub-programs combined
Specifications Used to Guide Definition	This report is broken into Addressee: member refunds (Items 1 through 6) or state refunds (Item 7). It is also separated by payment method: electronic transfer, paper check, credit card, other
Continuous Enrollment Requirement	Not applicable
Items 1-4, 6 and 7, Column C	Enter the number of contribution payment refunds that were returned during the reporting period.
Items 1-4, 6 and 7, Column D	Enter the total dollar value for all refunds returned during the reporting period.
Items 1-4, 6 and 7, Column E	Enter the average amount of the refund returned. Item 2 divided by Item 1.
Items 1-4 and 7, Column F	Enter the average length of time to process a power account contribution refund. To do this, • Identify the Julian date for which a refund was required. • Then subtract the Julian date the MCE mailed/returned the payment contribution as a refund.
Item 5	Sum the totals in Items 1 through 4 for Number of Refunds and Total Amount of Refunds. Compute a weighted average Amount of Refunds in Column E and Average Number of Days to Process Refund in Column F.
Item 8	Sum the totals in Items 5, 6 and 7 for Number of Refunds and Total Amount of Refunds. Compute a weighted average Amount of Refunds in Column E and Average Number of Days to Process Refund in Column F.

Report Number	**0709**
Report Title	**Report 0709: Non-Payment of POWER Account Contributions and Collectible Debt**
Purpose	To monitor initial POWER account payment cycles to ensure members are making payments and plans are accurately applying contributions.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Claims Lag?	Not applicable
Data Reported Each Submission	Data is reported for the activity in a single quarter in the Quarterly column. For submissions April 30: Include activity in the period Jan 1 – Mar 31 For submissions July 31: Include activity in the period Apr 1 – June 30 For submissions Oct 31: Include activity in the period July 1 – Sept 30 For submissions Jan 31: Include activity in the period Oct 1 – Dec 31
Lines of Business to Report	HIP only, all sub-programs combined
Specifications Used to Guide Definition	This report indicates members that failed to pay their POWER Account contribution based on their grace period status as well as members with collectible debt. These members are divided into four populations (Section 1931 Low Income Parent Caretaker, TMA, Pregnant Members and Newly Eligible) and five FPL levels (<22%, 23-50%, 51-75%, 76-100%, 101-138%). Conditionally eligible and HIP enrollees who are 60 days delinquent in making a full member contribution payment must be terminated from HIP coverage.
Continuous Enrollment Requirement	Not applicable
Column C-F	For Columns C-E, compute for each month of the quarter the number of members who failed to pay their monthly POWER Account contribution and have not yet exceeded the grace period. Then, distribute these members based on their Federal Poverty Level and aid categories according to the following categories: • For members with incomes <22% FPL, enter the total in Item 2. • For member with incomes between 23% FPL and 50% FPL, enter the total in Item 3. • For members with incomes between 51% FPL and 75% FPL, enter the total in Item 4. • For members with incomes between 76% FPL and 100% FPL, enter the total in Item 5.

	• For members with incomes between 101% FPL and 138% FPL, enter the total in Item 6. • For members designated as Low-Income Parent & Caretaker, enter the total in Item 7. • For members determined eligible for Temporary Medical Assistance (TMA), enter the total in Item 8. • For members who are pregnant, enter the total in Item 9. • For members who are designated as Newly Eligible for Medicaid, enter the total in Item 10. Column F contains calculated fields. For each row, the values in Columns C-E are summed.
Columns G-J	For Columns G-I, compute for each month of the quarter the number of members who failed to pay their monthly POWER Account contribution and have exceeded the grace period yet remain enrolled without a change in coverage. Then, distribute these members based on their Federal Poverty Level and aid categories according to the following categories: • For members with incomes <22% FPL, enter the total in Item 2. • For member with incomes between 23% FPL and 50% FPL, enter the total in Item 3. • For members with incomes between 51% FPL and 75% FPL, enter the total in Item 4. • For members with incomes between 76% FPL and 100% FPL, enter the total in Item 5. • For members with incomes between 101% FPL and 138% FPL, enter the total in Item 6. • For members designated as Low-Income Parent & Caretaker, enter the total in Item 7. • For members determined eligible for Temporary Medical Assistance (TMA), enter the total in Item 8. • For members who are pregnant, enter the total in Item 9. • For members who are newly eligible for Medicaid due to the Affordable Care Act, enter the total in Item 10. Column J contains calculated fields. For each row, the values in Columns G-I are summed.

Columns K-N	For Columns K-M, compute for each month of the quarter the number of members subject to POWER Account contributions who had collectible debt. Then, distribute these members based on their Federal Poverty Level and aid categories according to the following categories: • For members with incomes <22% FPL, enter the total in Item 2. • For member with incomes between 23% FPL and 50% FPL, enter the total in Item 3. • For members with incomes between 51% FPL and 75% FPL, enter the total in Item 4. • For members with incomes between 76% FPL and 100% FPL, enter the total in Item 5. • For members with incomes between 101% FPL and 138% FPL, enter the total in Item 6. • For members designated as Low-Income Parent & Caretaker, enter the total in Item 7. • For members determined eligible for Temporary Medical Assistance (TMA), enter the total in Item 8. • For members who are pregnant, enter the total in Item 9. • For members who are newly eligible for Medicaid due to the Affordable Care Act, enter the total in Item 10. Column N contains calculated fields. For each row, the values in Columns K-M are summed.

Report Number	**0801**
Report Title	**Report 0801: Vendor Contact Sheet**
Purpose	To confirm that the MCE staffing contact information is current and readily available for OMPP to contact key staff as necessary.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Data Reported Each Submission	This is a point-in-time report and an ad hoc report. For the quarterly submissions, report information even if no changes have occurred in staffing contract information. For submissions April 30: Report status as of March 31 For submissions July 31: Report status as of June 30 For submissions Oct 31: Report status as of Sept 30 For submissions Jan 31: Report status as of Dec 31 This report should also be submitted on an ad hoc basis if key staff or other primary business contact information changes during the quarter.
Lines of Business to Report	HHW, HIP and HCC
All Sections	Identify the required MCE contact information as provided for in the excel template. This information includes, but is not limited, to: • MCE general mailing address • General phone numbers • Web sites • Key contact personnel phone and fax numbers – (key staffing positions are identified which require completion) • Primary work site – (if the individual's primary work site is other than the primary business address, identify the city and state where the individual's primary work site is located)

	• Key contact email addresses It is the responsibility of the MCE to ensure accurate contact information is maintained and readily available to OMPP for key staff and business function areas.

Report Number	**0802**
Report Title	**Report 0802: Key Staff Vacancy**
Purpose	To confirm that the MCE is appropriately staffed when key staff vacancies occur.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Data Reported Each Submission	This is submitted quarterly and on an ad hoc basis if the MCE has vacancies for any of the positions listed below. The MCE must submit this report to OMPP per the contract within 5 business days of receiving notice to terminate employment or 5 days before the vacancy, whichever is earlier.
Lines of Business to Report	HHW, HIP and HCC
Column A	• Identify the vacant key staff position from those listed here that are required per the contract. • If all key staff positions are filled, insert "NONE" in this field. • Key staff include: • Chief Executive Officer, President, or Executive Director • Chief Financial Officer • Compliance Officer • Chief Information Officer (CIO) or Information Technology (IT) Director • Medical Director • Member Services Manager • Provider Services Manager • Special Investigation Unit Manager • Quality Management Manager • Utilization Management Manager • Behavioral Health Manager • Dental Manager • Data Compliance Manager • Pharmacy Director • POWER Account Operations Manager (HIP Only) • Transition Coordination Manager • Member Advocate/Non-Discrimination Coordinator • Grievance and Appeals Manager • Claims Manager

	• Care Management Manager • Health Equity Officer • HIPAA Contact • DCS Liaison
Column B	Enter the first and last name of the individual vacating the position
Column C	Enter if the person vacating the position was responsible for duties in HHW, HCC or HIP.
Column D	Enter the MCE's title of the staff position that will be left vacant.
Column E	Enter the termination date.
Column F	Describe a written plan describing how the coverage of duties will be managed in the interim to filling the position.
Column G	Provide the full name, email and telephone number for the contact person who will be responsible for overseeing the duties in the interim.
Column H	Describe a written plan describing the hiring process, timeline and target date for permanently filling the vacancy.
Column I	If the position remains vacant for a duration that extends to a new quarterly reporting period, provide an update to the report as to progress, revised target dates, or changes to the staffing plan.

Report Number	**0803**
Report Title	**Report 0803: Encounter Data**
Purpose	To monitor the MCE's utilization rates and costs. Comparisons may be made to submitted encounter data among the categories of service and across rate categories.
Format	Financial Reporting template
Periodicity of Submission	Quarterly
Data Reported Each Submission	The MCE must submit this report to OMPP no later than 55 calendar days after the lag period (i.e., approximately 145 calendar days after the end of the experience period).
Lines of Business to Report	HHW, HIP and HCC
Qualifications/ Definitions	This is a quarterly report. The MCE will receive: 1) an updated FRT template on the State's secure FTP site 60 days prior to the due date. The MCE will receive. 2) an updated eligibility file by the end of the month prior to the due date of the report (for example, if the report is due August 15, the MCE will receive an updated eligibility file by July 31). The MCE must fill in and submit the FRT as described in this manual. Instructions and data tables are also contained in the FRT. The MCE should submit cumulative year-to-date data each reporting period by completing the FRT. The Encounter Data (ED) report is based on those services with dates of service during the reporting period (i.e., the experience period) and for which the claims were paid, no later than 90 calendar days after the end of the reporting period (i.e., the claims lag period). Example 1, Reporting period #1 - Experience period (dates of service) – January 1st through March 31st; Lag period (claims paid for services incurred during experience period) – January 1st through June 30th; Report due date – August 25th. Example 2, Reporting period #2 - Experience period (dates of service) – January 1st through June 30th; Lag period (claims paid for services incurred during experience period) – January 1st through September 30th; Report due date – November 25th. The experience period and lag period are specified on the *Cover Page* tab of the FRT.

Performance Measures	In this year of the contract period, each MCE will be required to pay liquidated damages of $49,200 for each quarter that the HHW, HIP, and HCC quarterly encounter data report fails to meet the following requirements: a. is submitted in a timely, complete and accurate manner; and b. can be verified to a degree of at least 98% completeness for all claims (i.e., an incompleteness rate of no more than 2%). OMPP will use the MCE's encounter data, or other method of data completion verification deemed reasonable, to verify the completeness of the ED report in comparison to the MCE's encounter claims.
	QR-ED Instructions
Purpose - Instructions	This section provides instructions for submission of the QR-ED report via the FRT template. This section is intended to be used in conjunction with the FRT template. QR-ED instructions are provided in the five grey tabs of the FRT template. The instructions provided in each tab are described in this section.
Tab 1	This tab contains a log of all templates, instructions, or data table updates that occurred during the prior 24 months.
Tab 2	This tab contains a listing and description of all FRT tabs.
Tab 3	This tab contains a listing of all the fields the MCE is required to fill out on the FRT. For many, a description and notes are provided for clarification.
Tab 4	• **Claims processing** This section contains the following miscellaneous notes on claims processing: – Encounter data is assigned to an MCE based on the following hierarchy: a. using sender ID on the claim, if available b. using payer ID on COB file, if available c. using MCE ID on the claim, if available d. using MCE covering the member as of the date of the claim – When encounter data is submitted with NULL units, this is assumed to be zero units. – Encounter claims dollars represent actual MCE paid amounts from the EDW COB data file. – Claims fully denied by the MCE are not included in the encounter summaries. Also, if a claim was partially paid by the MCE, only the paid claim lines have been included in the utilization. Detail lines that have been denied by the MCE may be identified on the source data extract by selecting claim lines with I_MCO_deny = "Y".

	– Eligibility records are being counted as a half month of enrollment if the member is enrolled for 17 days or fewer in the calendar month. • **Unique key logic** This section is for informational purposes only and describes the logic Milliman uses to identify duplicate claims submissions. MCEs should use their own processes and judgment to identify multiple submissions of each claim in an attempt to avoid double counting.
Tab 5	This tab contains a crosswalk that includes the APR-DRG codes, revenue codes, HCPCS codes, or other information used to assign a category of service to each claim line. Note: Inpatient, home health, nursing home, and hospice claims are assigned to a category of service at the header level.
	Non-Benefit Cost and MLR Reporting
Purpose – Non-Benefit Cost and MLR Reporting	This section provides instructions for submitting non-benefit cost and MLR information, the two cream-colored tabs on the FRT. The non-benefit cost information is used to monitor MCE non-benefit costs. The MLR reporting is used to monitor MCE financial performance.
Tab 1	MCEs should report all non-benefit expenses in the *Non-Benefit Cost* tab of the FRT, categorizing expense type as accurately as possible.
Tab 2	MLR reporting should be updated quarterly, with a focus on primary revenue and incurred claims categories. This is needed to monitor MCE financial performance. Taxes, expenses to improve health quality, and smaller revenue or expense items such as P4O may be updated on an annual basis for final reporting, due August 15th of each year. MLR reporting instructions in the reporting manual are replicated in the MLR tab of the FRT.
	Revenue and Claims Reporting
Purpose – Revenue and Claims Reporting	Key revenue and claims reporting is submitted on the nine blue tabs of the FRT. Collectively, these tabs are used to reconcile to MCE financial revenue and payment records, and to evaluate the timeliness and completeness of encounter data submissions to the State encounter data warehouse.
Tab 1	This tab should be used by the MCE to provide summarized monthly expenditures for subcapitated services by vendor and category of service.

	Subcapitated expenditures should be split by type of expense (i.e. shadow price, care coordination, subcapitated admin).
Tab 2	This tab should be used by the MCE to provide summarized monthly third-party liability avoidance and recoveries by population, incurred month and paid month.
Tab 3	This tab should be populated with the number of capitation payments and the total dollar amount received by the MCE by month and rate cell. This data should be based on payments received rather than actual enrollment experience. The number of capitation payments should reflect the type of capitation received. If the MCE received one-half capitation payment, then it should be counted as 0.5. If a capitation is voided and replaced, only the replacement should be counted as a capitation payment.
Tab 4	This tab should be populated with enrollment information from the file provided by Milliman to the MCE the month prior to the due date of the report. Any discrepancies between the MCE's actual enrollment, as per the 834 file, should be noted in the corresponding columns within this tab.
Tab 5	This tab should be populated with the number of deliveries and notifications of pregnancy experienced by the MCE for eligible members regardless of whether a payment has been received by the MCE. In addition, the MCE should provide the number of delivery case rate payments and notification of pregnancy payments received and the total amount of such payments by month and population.
Tab 6	This tab should be populated with the total benefit costs by month, rate cell, category of service, and payment source. For subcapitated services only the benefit cost should be reported in this tab (subcapitated administrative expenses should be excluded). Claims reported on the *Missing claims* tab should also be included here.
Tab 7	This tab should be populated with the net claims costs for claims that have not yet been successfully submitted to the State's encounter data warehouse, such as rejected claims for which a replacement is not already in the State's encounter data warehouse. The claims on this tab should be a subset of the claims reported on the *Paid Claims* tab.

Tab 8	This tab should be populated with the total units and benefit cost expenditures for members that were not enrolled with the MCE as of the date of service, as per the enrollment file provided by Milliman the month before the FRT is due. It is expected that these claims would ultimately be recouped from providers.
Tab 9	This tab has four sections and is to be populated with claim expenditures as follows: 1. Paid Claims: Claims incurred during the base data period and paid during the payment period. 2. Paid Claims - Incurred before Data Period: claims incurred before the data period but paid within the payment period. 3. Incurred but Not Paid: Claims incurred during the data period but not yet paid. Incurred but Not Paid - Before Data Period: claims incurred before the data period but not yet paid.
	Miscellaneous
Purpose - Miscellaneous	The last three tabs of the FRT may be used as follows: • The data validation tabs assist MCEs with reviewing FRT reporting for internal consistency before submission. It is not required that all validation checks be passed, as long as the MCE understands the reason for the discrepancy. However, MCEs should review each validation check to avoid unnecessary errors in their submissions. • The Notes tab may be used by the MCE to explain anomalies or unusual reporting methods. FRT reporting requires certification by a responsible party as to the accuracy and completeness of the information provided.
Tab 1	Reconciles data reported by the MCE on the FRT to highlight internal discrepancies in reporting. This tab is intended to assist the MCE in verifying their inputs before submitting the data to Milliman. MCEs should investigate any discrepancies, and either correct or provide a short explanatory note. The *Data Validation* tab contains the following summaries: a. Totals – summarizes the totals of the inputs from each tab populated by the MCE. b. Paid Claims – shows PMPMs by population and major category of service based on expenditures reported on the *Paid Claims* tab. c. Enrollment – compares the inputs from the *Cap Payments Exposure, and Deliveries* tabs by year and population. d. Subcapitation – compares the information reported on the *Subcap* tab to that reported on the *Paid Claims* tab.

	e. TPL – compares the TPL avoidance reported on the *TPL* tab to that reported on the *Paid Claims* tab. MLR – Compares information reported on the *MLR* tab to other inputs provided across the FRT.
Tab 2	This tab is provided for the preparer to enter any notes, comments and/or observations about the data provided on the FRT.
Tab 3	This tab is for the FRT preparer to certify that the data inputs are complete and accurate. A signed, PDF copy of this form should be submitted to Milliman along with each quarterly FRT submission.

	0804
Report Title	**Report 0804: Capitation Reconciliation Report**
Purpose	To monitor the MCE's reconciliation of premiums received from the State via the 820 - Capitation file.
Format	MCE format
Periodicity of Submission	Quarterly
Data Reported Each Submission	This is a point-in-time report. Data is reported for the activity in a single quarter. For submissions April 30: Include activity in the period Jan 1 – Mar 31 For submissions July 31: Include activity in the period Apr 1 – June 30 For submissions Oct 31: Include activity in the period July 1 – Sept 30 For submissions Jan 31: Include activity in the period Oct 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Qualifications/ Definitions	This is a quarterly report due the last day of the month following the reporting quarter. The MCE is expected to confirm payment totals, returning any identified overpayments made to the plan.
All Sections	The MCE must submit a reconciliation report HIP membership capitation, as well as a report for POWER accounts. Each membership reconciliation report should be summarized by population: rate group, gender, and age band (if applicable). The report should indicate summary totals of membership and capitation separated by full, half and maternity premium totals. The report should indicate summary totals of adjustments for prior quarter capitation payments applied during the reporting quarter. The report should indicate any identified discrepancies in expected premiums in comparison to membership rosters. This may be either identified over or underpayments but should be indicated as such. The plan is expected to notify and return any overpayments to the State within forty-five (45) calendar days of discovering the discrepancy. In each reporting period, the plan may indicate prior period discrepancies that have not yet been resolved either as recoupment to the State or as additional premiums to the MCE. The POWER account reconciling report should indicate summary analysis applied by the health plan that validates receipt and application of POWER account payments during the reporting quarter. The report should separately indicate any identified adjustments applied during the reporting period. The report should indicate any identified discrepancies and overpayments that should be returned to the State.

Report Number	**0805**
Report Title	**Report 0805: Physician Incentive Plan**
Purpose	To identify and describe the MCE's provider incentive agreements between various contractual relationships
Format	MCE format
Periodicity of Submission	Annually
Data Reported Each Submission	January 31
Lines of Business to Report	HHW, HIP and HCC combined
Qualifications/ Definitions	This is an annual and ad-hoc report. On an ad-hoc basis, the report must be supplied for any new contract at the start of the contracted arrangement regardless of the start date. The MCE must submit a listing of physician incentive plans (PIP) in place. Arrangements may include payment structures that promote quality of care outcomes, pays for enhanced services, or limits the amount or duration of services made available to a member. If, however, there is a financial arrangement that meets the strict definition of a physician incentive plan described within, at a minimum the AN-PIP report must contain the attributes described below. According to the definitions outlined by 42 CFR § 422.208: ***Physician incentive plan*** is described as, "…any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee." ***Risk threshold*** is defined as, "The maximum risk, if the risk is based on referral services (i.e. those services not provided directly by the party being paid under the contract), to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk. This is set at 25 percent risk." ***Stop-Loss Protection*** is defined as, "Stop-loss protection is coverage designed to limit the amount of financial loss experienced by a health care provider. PIP regulations require that physicians and physician groups be protected from risk beyond the stop-loss threshold." An MCE is permitted to operate a physician incentive plan only if: • no specific payment is made directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee; **and**

	• the disclosure, computation of substantial risk, stop-loss protection, and enrollee survey requirements are met. CMS considers the MCE as the first party in the relationship and considers the "Provider" as the second party of the contractual relationship. If there are contractual arrangements in place that cause substantial financial risk, the following information must be disclosed.
Item 1	The MCE should confirm whether a PIP is in place for the current and future contracting period.
Item 2	Describe the relationship between the contracted provider, and the type of provider. This should describe whether this is a new or modified arrangement. The MCE must correctly represent the arrangement of contracting and subcontracting relationships. For example, if the MCE maintains a PIP between the MCE and a physician group, it should aggregate all physician groups it contracts with that have substantially the same incentive agreements and stop-loss requirements. Separately, the MCE should describe any plan between a physician group to physician, to enter the physician group-physician arrangements only for the physicians associated with those provider groups.
Item 3	An explanation is to be provided as to the incentive arrangement. This should describe whether the arrangement is based upon a withhold, bonus, or capitation.
Item 4	Describe the percentage and calculation method utilized to determine that the substantial risk threshold has been met.
Item 5	Describe the panel size, whether patients are pooled, the pooling methodology utilized to determine if a substantial financial risk exists.
Item 6	Describe the stop-loss protections in place, including the type of coverage (e.g., per member per year, aggregate), the threshold amounts, and any coinsurance required for amounts above the threshold.
Item 7	Detail what information will be supplied to a member or potential enrollee that requests information regarding the provision of a PIP and the method to request and supply that information.

Report Number	**0806**
Report Title	**Report 0806: Indiana Department of Insurance Filing**
Purpose	To monitor the MCE's financial solvency and confirm the MCE's financial ability to administer health care service delivery to its members.
Format	IDOI format
Periodicity of Submission	Quarterly
Data Reported Each Submission	No later than 45 calendar days after the end of the quarter (May 15, Aug 15th) except for the fourth quarter (i.e., annual) report which is due March 1st.
Lines of Business to Report	HHW, HIP and HCC combined
Qualifications/ Definitions	The MCE must submit copies of its quarterly and annual IDOI filings to OMPP.
All Sections	Insert required data per the IDOI filings using the National Association of Insurance Commissioners (NAIC) format.

Report Number	**0807**
Report Title	**Report 0807: Insurance Premium Notice**
Purpose	To monitor insurance premium renewals annually.
Format	MCE format
Periodicity of Submission	F02
Data Reported Each Submission	January 31
Lines of Business to Report	HHW, HIP and HCC combined
Qualifications/ Definitions	The MCE must obtain insurance and submit new policies or premium renewal notices to OMPP. The MCE must provide the requested information throughout the year to OMPP during on-site monitoring visits upon request.
All Sections	The MCE must submit for OMPP's review and approval no fewer than 30 calendar days before a replacement policy becomes effective or the previously approved policy's renewal is due: • The policy for re-insurance • The certificate of insurance coverage for other required insurance

Report Number	**0901**
Report Title	**Report 0901: PMP Assignment Report**
Purpose	To monitor the method and volume of PMP selection and assignment linkages to an MCE's membership.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Data Reported Each Submission	This is a rolling 12-month report. Data should be refreshed with each quarter's submission. The anchor date is the last day of the reporting quarter. For submissions April 30: Reporting Period is Apr 1 – Mar 31 For submissions July 31: Reporting Period is July 1 – June 30 For submissions Oct 31: Reporting Period is Oct 1 – Sept 30 For submissions Jan 31: Reporting Period is Jan 1 – Dec 31
Lines of Business to Report	HHW, HIP and HCC
Specifications Used to Guide Definition	**"Smart" Logic:** For the purposes of this report, "smart" logic is the pre-defined State hierarchy that is to be utilized to facilitate PMP to member linkages. Internal MCE assignment reason codes should be mapped to indicate when the following information is utilized to select a PMP on the behalf of a member: • Right Choices Program PMP Assignment • Member's PMP assignment within the last 12 months • Family member's current PMP • Family member's previous PMP • PMP in previous group • PMP in family member's current group or previous group When any of this information is applied, the total of the mapped reason codes equals the total assignments made with "smart" logic as pre-defined by the State. **"Default" Logic:** For the purposes of this report, any method excluding the "smart" logic that is utilized by the MCE to facilitate PMP to member linkages is defined as default logic. Default logic is not pre-defined by the State, but must receive State approval.

	A new member may be identified utilizing the 834 – Benefit Enrollment and Maintenance Transaction for those records with an "INS03 012" value. This is a member that is either new to the network or had a break in eligibility and has regained eligibility.
Item 1	Enter the total number of newly-assigned members received on the enrollment roster during the reporting period.
Item 2	Enter the number of members who self-selected a PMP during the reporting period.
Item 3	Enter the number of members who were auto-assigned using "smart" logic.
Item 4	Enter the number of members who were auto-assigned using an approved default logic that does not include "smart" logic.
Item 5	Enter the total number of members assigned a PMP during the reporting period. This number may not be an exact total of Items 2, 3, and 4 since a member may have multiple types of assignments occur during the reporting period. However, the percent of members assigned under each method is automatically computed in the Percent of Total column. The sum of the three percentages may be greater than 100%.
Item 6	Enter the total number of all members assigned a PMP as of the last day of the reporting period, regardless of when a PMP assignment was made.
Item 7	Enter the total number of members that have an open network status either due to PMP assignment logic that has not been applied or due to a lack of PMP availability within the required access targets.

Report Number	**0902**
Report Title	**Report 0902: Count of Enrolled Providers**
Purpose	To assess the adequacy of the MCE's provider network
Format	OMPP Excel template
Periodicity of Submission	Annually, due October 31
Data Reported Each Submission	Count of providers under contract within each category as of September 30
Lines of Business to Report	HHW, HIP, and HCC separately
Specifications	Report the unique count of providers under contract with the MCE by provider specialty and by county location. Include only those providers that (a) have an IHCP ID and (b) can bill separately under IHCP. Although ordering/prescribing providers may enroll under IHCP and may have their own IHCP ID, do not include ordering/prescribing providers on this report.
	Enter the number of providers contracted with the MCE in the HHW program as of September 30 each year. For facilities (Columns C through I), count each facility (if the provider has more than one) in the county where it is physically located. For individual providers (Columns J through AQ), count the provider in the county where the rendering provider is located. Do not use billing home office locations for assignment. Whenever possible, use the IHCP Provider Type and Specialty that is assigned to the provider to determine the appropriate column for counting purposes. If an IHCP provider has more than one specialty, categorize the provider in the specialty column for which the MCE intends to utilize the provider to deliver services to its members. The development of the columns in this report reference information from the IHCP Provider Enrollment document published by DXC, Library Reference Number PROMOD00015, published July 26, 2018. For some specialties, there is not a pre-defined IHCP Provider Type or Specialty assigned. In these situations, an N/A appears for IHCP Provider Type and Specialty. Instead of the IHCP Provider Type and Specialty, use the nationally-recognized taxonomy code for the provider to assign providers in the specialty categories requested. Each facility/provider shown on this report should appear in only one column and in only one county. It is understood that providers often serve members in multiple counties. The total unique providers are summed at the top of each column. Therefore, these counts represent the total unique providers (locations if facilities) under contract with the MCE for the program.

Report Number	**0903**
Report Title	**Report 0903: Member Access to Providers**
Purpose	To assess the number of members with access to each provider specialty that is outside of the OMPP target driving distance range.
Format	OMPP Excel template
Periodicity of Submission	Annually, due October 31
Data Reported Each Submission	The number of members enrolled with the MCE in September of each year that do not have access to the specific specialty provider within the target driving distance established by the OMPP.
Lines of Business to Report	HHW, HIP and HCC separately
Specifications	Use the capitation payment file provided to you by the OMPP to identify the total members enrolled with the MCE in each line of business in the month of September each year. Segment the enrollees into each of the 92 counties by using the home address provided to you by the OMPP for each member. Each member should be assigned to only one county on this report. If there is a member with an out-of-state or blank home address, exclude the member from this analysis. Report the total members enrolled, by county, in Column C. Each member assigned to a county on the report will then be tested to determine the distance that the member would need to travel to seek the services of each provider category listed on the report. Note that the columns for the provider categories are the same as shown in Report 0902. However, there are some specialties reported on the 0902 report for which the OMPP does not have an access standard. For these specialties, the column has been shaded to indicate that the MCE is not required to report values for these specialties. Additionally, in this report, the primary medical providers that are listed in three separate columns in Report 0902 (physicians, APRNs, and physician assistants) are merged into one column in Report 0903 since any of these providers may meet the distance requirement for primary medical provider. The MCE will utilize is geoaccess software to determine the count of members who do not meet the number of providers/distance standards for each specialty shown in rows 11 and 12 in the report. Report the count of members in each county that do **not** meet the distance standard for each provider specialty.

Report Number	**0904**
Report Title	**Report 0904: Subcontractor Compliance Summary**
Purpose	To identify the MCE's subcontractors and document the MCE's oversight of delegated activities.
Format	OMPP Excel template
Periodicity of Submission	Annually, due January 31
Data Reported Each Submission	Subcontract arrangements held in the prior calendar year
Lines of Business to Report	HHW, HIP and HCC combined
Qualifications/ Definitions	The MCE must provide the requested information throughout the year to OMPP during on-site monitoring visits. For this report, a subcontractor may be an entity that manages and administers health care service delivery functions, such as claims processing, or may be an entity that provides for direct patient care, such as a Managed Behavioral Healthcare Organization (MBHO). PMP and specialty physician contracts are not included in this report.
Performance Measures	The MCE must notify OMPP and request OMPP's approval 60 calendar days prior to the use or change of any subcontractor or subcontractor's agreement.
Item 1	Consecutively number subcontractors listed on the report.
Item 2	Identify using the drop-down list if the listed subcontractor meets the definition for minority business enterprise (MBE), women business enterprise (WBE) or veteran business enterprise (VBE).
Item 3	Identify using the drop-down list if the listed subcontractor is engaged with HHW, HIP, HCC, or ALL lines of business.
Item 4	Identify the MCE's subcontractors that deliver contracted services. OMPP requires all subcontractors to be identified that were active during the reporting period. This includes terminated contracts that were active for only a portion of the reporting period. Insert the name of the MCE's subcontractor as listed on its contract with the MCE.
Item 5	Identify using the drop-down list the delegated activities the subcontractor performs that support the MCE's contract with the State using the descriptions below: <u>Delegated Activities</u> Accounts Receivable/Accounts Payable Behavioral Health

	Claims Processing/Data Systems Disease Management Network Development Non-emergent Transportation Member Services Pharmacy Benefit Management Prior Authorization/Medical Management Provider Credentialing Provider Services Website Development/Management Direct Patient Care Other, identify
Item 6	Clarify the activity performed that is outside the scope of services described from the above list.
Item 7	Enter the effective date of the subcontractor's contract with the MCE (i.e., the date the subcontractor will begin delivering contracted services). Enter date in MM/DD/YY format.
Item 8	Enter the end date of the subcontractor's current contracted term. End dates cannot extend beyond the termination date of the MCE's contract with the State. Enter date in MM/DD/YY format.
Item 9	Identify using the drop-down list the type of financial arrangement, either risk or non-risk based, under which the subcontractor will deliver services by using the following descriptions: **Non-risk contract:** the subcontractor has no risk or the risk is less than five percent of the MCE's revenue from the HIP contract. **Risk contract:** the subcontractor has risk equaling five percent or more of the MCE's revenue from the HIP contract.

Item 10	Identify using the drop-down list if the MCE collected the required quarterly financial information when the subcontractor's financial arrangement is "Risk" by indicating the following options: **Yes:** the MCE has collected the required financial information each quarter of the prior calendar year. **No:** the MCE has not collected the required financial information each quarter of the prior calendar year. **NA:** the sub-contract does not carry a risk of five percent or more. Required performance data includes a statement of revenue and expenses, a balance sheet, cash flows and change in equity/fund balances as well as incurred but not received (IBNR) estimates.
Item 11	Identify using the drop-down list the subcontractor's stop-loss insurance coverage arrangement using the following indicators: **Yes:** this subcontractor has its own stop-loss coverage **No:** this subcontractor does not have its own stop-loss coverage **NA:** Stop loss does not apply to this subcontractor
Item 12	Identify using the drop-down list the subcontractor's participation in the MCE's internal committee structure using the following descriptions: **>50%:** Participates 50 percent or more in one or more committee(s) **<50%:** Participates less than 50 percent in one or more committee(s) **None:** Does not participate in any internal MCE committee(s) Enter one of the above options.
Item 13	If the sub-contractor is participating in an MCE committee(s), indicate the name(s) of committee(s) in which the subcontractor participates.
Item 14	Identify the monitoring activities the MCE employs to oversee the subcontractor's compliance with the terms of the MCE's contract with the State. Include routine, annual, and ad-hoc monitoring activities that provide the MCE assurances that the subcontractor's performance is adequate.
Item 15	Enter the date any formal or informal corrective actions were implemented. If no corrective actions were taken leave this field blank.

	Enter date(s) for each corrective action taken during the reporting period in MM/DD/YY format.
Item 16	Enter the date the MCE confirmed the subcontractor's activities were again in compliance. If there were no corrective actions leave this field blank. Enter date(s) for each corrective action taken during the reporting period in MM/DD/YY format.
Item 17	Briefly describe the subcontractor's outcomes for any corrective action instituted by the MCE.
Item 18	Identify the date OMPP approved the subcontractor agreement. Enter date in MM/DD/YY format.

Report Number	**0905**
Report Title	**Report 0905: 24-Hour Availability Audit**
Purpose	To monitor members' access to PMPs outside standard business hours.
Format	OMPP Excel template
Periodicity of Submission	Annually, due January 31
Data Reported Each Submission	Results of the annual 24-hour availability audit
Lines of Business to Report	HHW, HIP and HCC combined
Specifications	Members should be able to access PMPs 24-hours-a-day, seven days a week, for urgent and emergent health care needs, regardless of a holiday. Therefore, PMPs must have a mechanism in place to ensure that members can make direct contact with their PMP or the PMP's clinical staff person through a toll-free member services telephone number 24-hours-a-day, seven-days-a-week. The MCE must randomly select PMPs to receive test calls each year. The sample size must include 100 percent of high-volume providers and 5% of enrolled providers within each county (a minimum of 1 PMP per county). High volume providers are defined as providers that include the top 10 percent of the enrolled membership. The audit may occur throughout the previous calendar year or during a dedicated audit time period established by the MCE. PMPs are deemed available to provide services if they: • answer the phone themselves, • designate an employee, • hire an answering service, or • use a pager system to facilitate members' contact with an on-call medical professional 24-hours-a-day, seven-days-a-week. To be considered compliant, PMPs must also provide instruction for life-threatening situations in all four of the above situations. The PMP must provide appropriate direction to the member to contact 911 or the nearest emergency department. MCEs must notify PMPs who are found non-compliant with the 24-hour availability requirement and must put corrective actions in place within 30 days of notification and re-survey within three months. The MCE must monitor non-compliant providers in the following year to determine availability and

	indicate these re-surveys separately on the survey tool. The MCE must complete these calls *in addition* to the annual monitoring sample.
Item 1	Enter the IHCP provider ID of the provider that is being audited. A provider may be a part of a group practice. The intent of this report, however, is to audit individual rendering providers.
Item 2	Enter the last name of the provider being audited.
Item 3	Enter the first name of the provider being audited.
Item 4	Select yes or no to indicate if the provider (either individually or as part of a group practice) meets the definition of High-Volume Provider as described above in the Specifications section.
Item 5	Select from the drop-down list the primary care specialty assigned to the provider associated with its IHCP ID.
Item 6	Select from the drop-down list the primary county where the provider being audited serves members.
Item 7	Enter the date that the audit call was placed. Enter in mm/dd/yy format.
Item 8	Enter the time that the audit call was placed. Enter in 24-hour format, e.g. 10:30 pm is 22:30
Item 9	Select yes or no if this provider is a repeat survey from last year's audit.
Item 10	Select yes or no if a live voice response was provided during the audit call. A live voice response can be from the provider him/herself, from an employee of the provider's office, or from an answering service.
Item 11	Select yes or no if a paging system was utilized during the audit call.
Item 12	Select yes or no if, regardless of the mode of communication in Items 10 and 11, the communication back to the member included instructions for life-threatening situations.
Item 13	Select yes or no if the MCE deemed that corrective action was required with the provider as a result of the audit.
Item 14	Enter the date that the MCE gave the corrective action to the provider. Enter in mm/dd/yy format.

<table>
<tr><td>Report Number</td><td>0906</td></tr>
<tr><td>Report Title</td><td>Report 0906: Provider Directory Audit</td></tr>
<tr><td>Purpose</td><td>To monitor the validity of the information in the MCE’s online provider directories.</td></tr>
<tr><td>Format</td><td>OMPP Excel template</td></tr>
<tr><td>Periodicity of Submission</td><td>Annually, due January 31</td></tr>
<tr><td>Data Reported Each Submission</td><td>Results of the MCE provider directory audit</td></tr>
<tr><td>Lines of Business to Report</td><td>HHW, HIP and HCC combined</td></tr>
<tr><td>Specifications</td><td>Members should have reliable information to access providers listed in the MCE’s online provider directories on their member websites. The MCE must select a minimum of 500 contracted providers listed in its online directories to verify the information for the provider that appears in the directory

The audit may occur throughout the previous calendar year or during a dedicated audit time period established by the MCE. The method for auditing the provider’s information may be telephonic or in-person from MCE Provider Representative meetings at the provider’s location.

The sample size must include each of the provider types/specialties listed in Report 0902. Specifically, the sample must include:
Minimum of 40 providers in Provider Specialties 316, 318, 328, 344 or 345 (PMPs-Physicians)
Minimum of 40 providers in Provider Specialties 271 or 274 (General Dentistry)
Minimum of 20 providers in Provider Specialty 328 (OB/GYN)
Minimum of 30 providers in Provider Specialty 240 (Pharmacy)
The remaining 370 in the sample must be evenly represented by selecting 10 providers from each of the remaining columns in Report 0902. Select ten from each of these provider specialty categories (IHCP codes or name listed if no IHCP code):
<table>
<tr><td>010</td><td>100</td><td>314</td><td>330</td><td>339</td><td>Endocrinologists</td></tr>
<tr><td>011</td><td>272</td><td>317</td><td>180</td><td>340</td><td>Hematologists</td></tr>
<tr><td>050</td><td>110,111,114</td><td>324</td><td>273</td><td>341</td><td>Infectious Disease Specialists</td></tr>
<tr><td>080-088</td><td>615</td><td>325</td><td>331</td><td>173</td><td>Rheumatologists</td></tr>
<tr><td>300</td><td>311</td><td>326</td><td>332</td><td>343</td><td></td></tr>
<tr><td>835, 836</td><td>312</td><td>171</td><td>333</td><td></td><td></td></tr>
</table></td></tr>
</table>

	090-095 | 313 | 329 | 170 | | If the MCE does not have 10 providers in one of the 37 categories above, then the MCE should note this in the report submission and survey 100% of contracted providers in the specialty category.
Item 1	Enter the IHCP provider ID of the provider that is being audited. A provider may be a part of a group practice. The intent of this report, however, is to audit individual rendering providers.
Item 2	If the provider being audited is an individual, enter the word Individual; for all others, enter the word Non-Individual (e.g., facility, hospital, pharmacy).
Item 3	If the provider being audited is a facility or corporate entity, enter the provider entity name.
Item 4	If the provider being audited is an individual practitioner, enter the last name of the provider.
Item 5	If the provider being audited is an individual practitioner, enter the first name of the provider.
Item 6	Enter the 2-digit Provider Type assigned to this IHCP provider.
Item 7	Enter the 3-digit Provider Specialty assigned to this IHCP provider.
Item 8	Select yes or no to indicate if the provider contracts with the MCE in the HHW program.
Item 9	Select yes or no to indicate if the provider contracts with the MCE in the HIP program.
Item 10	Select yes or no to indicate if the provider contracts with the MCE in the HCC program. If the MCE does not have a contract for HCC with the OMPP, then select no.
Item 11	Enter the date that the audit call was placed. Enter in mm/dd/yy format.
Item 12	Select yes to indicate if the office phone number as shown in the MCE's online directory is correct for this provider and is in service. If the phone number does not match, then select no. If the provider's office does not answer the phone (or does not provide an outbound voice message), then select no.
Item 13	Select yes to indicate if the office street address as shown in the MCE's online directory is correct for this provider. If the provider cannot confirm the same street address, then select no.
Item 14	If Item 2 = individual, select yes or no to indicate if the individual provider still serves patients at the street address listed in the MCE provider directory for the practitioner.
Item 15	If Item 2 = individual, select yes or no to indicate if the provider is accepting new HHW members as patients. If Item 8 = no, then select no for this item.
Item 16	If Item 2 = individual, select yes or no to indicate if the provider is accepting new HIP members as patients. If Item 9 = no, then select no for this item
Item 17	If Item 2 = individual, select yes or no to indicate if the provider is accepting new HCC members as patients. If Item 10 = no, then select no for this item

Report Number	**1001**
Report Title	**Report 1001: Quality Management and Improvement Program (QMIP) Work Plan and Quarterly Updates**
Purpose	To assess progress throughout the year on items in the MCE's QMIP. The QMIP Work Plan: a) Identifies how the MCE monitors its strategy for improving the delivery of health care benefits and quality of care and service to its members and b) Aligns with the State goals as documented in the Quality Strategy. c) Provides quantitative data updates to demonstrate on-going progress towards goals. This includes monitoring for sustained improvement of previously closed Quality Improvement Projects. The QMIP Work Plan and updates must be submitted quarterly.
Format	Submit approved MCE Quality Improvement Workplan.
Data Reported Each Submission	 QMIP QIP Workflow.docx **Reporting Submission Example:** January 31 – Q4 quarterly updates to prior year's work plan April 30 – Q1 new calendar year work plan and quarterly update July 31 – Q2 quarterly work plan updates October 31- Q3 quarterly work plan updates
Lines of Business to Report	HHW, HIP and HCC combined. NOTE: The MCE may choose to submit a separate QMIP work plan, if desired.
Specifications	This is a working document and should be continually updated. If the MCE chooses to submit a combined work plan for the Medicaid programs listed above, specific activities and goals for each program must be clearly delineated and tracked.

Report Number	**1002**
Report Title	**Report 1002: Quality Improvement Projects and Quarterly Updates**
Purpose	To provide an assessment of the effectiveness of each QIP conducted by the MCE.
Format	OMPP/QSource template for QIPs
Periodicity of Submission	Quarterly
Data Reported Each Submission	Please see dates below. For Quarter 1, the OMPP/QSource template for QIPs will be completed in its entirety. For Q2-Q4, only Section 8 will be updated. Section 9 will be completed based on the annual evaluation date.
Lines of Business to Report	HHW, HIP and HCC combined
Qualifications/ Definitions	**Reporting Submission Example:** April 30- Q1 (New QIPS: Include completion of data elements in steps 1-7. Existing QIPS: Update steps 1-7 as directed by QSource recommendations All: Section 8) July 31- Q2 update (Section 8 only) October 31- Q3 update (Section 8 only) January 31- Q4 update (Section 8 only) Important to note: Based on the evaluation date for each QIP, complete Section 9. The OMPP/QSource template should be submitted for <u>EACH</u> QIP. Please refer to Appendix D for complete instructions when filling out the template. The QIP Report template was built by QSource and aligns with CMS protocols for Quality Improvement Projects. OMPP requests that MCEs complete QIP Reports and submit them in this format. The QIP Report is divided into the following nine sections. 1. State the Selected QIP Topic 2. State the QIP Aim Statement 3. Identify the QIP Population

	4. Describe the Sampling Method 5. Describe the Selected QIP Variable and Performance Measures 6. Describe Valid and Reliable Data Collection Procedures 7. Analyze Data and Interpret QIP Results 8. Describe Improvement Strategies 9. Assess for Significant and Sustained Improvement

Report Number	**1003**
Report Title	**Report 1003: Quality Management and Improvement Committee Meetings' Minutes**
Purpose	To review the issues the MCE is addressing during its internal quality management and improvement committee meetings and evaluate the correlation of internal committee activities to the MCE's quality management and improvement work plan goals.
Format	MCE format
Periodicity of Submission	Quarterly
Lines of Business to Report	HHW, HIP and HCC combined
Qualifications/ Definitions	This is a quarterly report to be submitted to OMPP on the last day of the month following the end of the reporting quarter or at OMPP's discretion may be requested on-site. The MCE should provide the Quality Management and Improvement Committee meeting minutes for all committee meetings that occurred during the reporting quarter.
All Sections	Narrative text on the meeting's minutes must include: • MCE name • Name of committee • Date of meeting • Names and position titles of attendees • Subcommittees, work groups or task force reports or updates • Agenda items • Narrative description of agenda items, issues, discussion, planned actions, follow-up, responsible party, dates due, problem resolution, next steps, etc. • Date of next scheduled meeting

Report Number	**1004**
Report Title	**Report 1004: HEDIS Data**
Purpose	Evaluate the MCE's data compiled for its annual Healthcare Effectiveness Data and Information Set (HEDIS®) audit survey
Format	HEDIS
Periodicity of Submission	Annually
Data Reported Each Submission	June 15 or on the date the data is due to NCQA, whichever is earlier, for the preceding calendar year's data
Lines of Business to Report	HHW, HIP and HCC separately
All Sections	Provide the same audited data to OMPP that is provided to NCQA.

Report Number	**1005**
Report Title	**Report 1005: HEDIS Compliance Auditor's Final Report**
Purpose	Assess the MCE's compliance with the Healthcare Effectiveness Data and Information Set (HEDIS®) Technical Specifications reporting requirements when reporting annual HEDIS® rates.
Format	HEDIS
Periodicity of Submission	Annually
Data Reported Each Submission	The MCE must submit this report to OMPP within ten business days of receiving the report from the Auditor.
Lines of Business to Report	HHW, HIP and HCC combined
All Sections	Submit Auditor's final report.

Report Number	**1006**
Report Title	**Report 1006: Quality Management and Improvement Program Description**
Purpose	To describe the MCEs Quality Management and Improvement program and its plan to improve quality for the current year.
Format	MCE approved Program Description document
Periodicity of Submission	Annually; April 30
Data Reported Each Submission	
Lines of Business to Report	HHW, HIP and HCC combined (may be combined or submitted separately for each program)
Qualifications/ Definitions	If multiple programs are included in the program description, the MCE must clearly delineate any quality improvement plans for each program. Example: If the MCE notes lagging performance in a specific program, it is expected to see the plan to address the lagging performance specific to the Medicaid program in the over-arching program description. The MCE must align areas of focus with those in the State Quality Strategy.

Report Number	**1007**
Report Title	**Report 1007: Quality Management and Improvement Program Evaluation**
Purpose	To review the effectiveness and efficiency of the MCEs Quality Program.
Format	MCE approved Program Evaluation document
Periodicity of Submission	Annually; May 30
Data Reported Each Submission	
Lines of Business to Report	HHW, HIP and HCC combined (may be combined or submitted separately for each program)
Qualifications/ Definitions	If multiple programs are included in the evaluation, the MCE must clearly delineate evaluation activities for each specific program. Example: If the MCE focused improvement activities to address lagging performance for a specific measure in a specific program, the evaluation must clearly indicate if goals were met and if not met, how the MCE plans to address in the next year.

Report Number	**1101**
Report Title	**Report 1101: Program Integrity Notification Report**
Purpose	The MCEs will report all fraud, waste, and abuse in open case audits/investigations on a monthly basis. The reported data will be used by the OMPP PI to assess the timely processing of audit/investigation cases, the types of allegations (complaints), and number of submitted cases to PI. OMPP PI is no longer requiring MCE to report on tips received. MCEs should track cases on this report from when the case was initiated, which could be the date complaints/allegations were first received, to when the MCE either closes or refers the case to PI. All drop-down menus have been removed from this report to ease the MCE's administrative burden.
Format	OMPP Excel template
Periodicity of Submission	Monthly
Lines of Business to Report	HHW, HIP and HCC combined
Qualifications/ Definitions	This is a monthly report. The reporting period is each calendar month. The MCE must submit the report to OMPP within ten (10) business days following the end of the reporting month. This report is required for all three programs: HCC, HHW and HIP. All programs are to be reported cumulatively; only ONE report is requested from the MCEs. Please place the file on SharePoint under the HIP folder. This report must include program integrity actions taken by the MCE and all subcontractor delegated entities such as transportation, pharmacy, vision, mental health, and dental vendors.
Item 1	MCEs may utilize this field for additional identifying information, such as an internal case tracking number.
Item 2	Enter the last name, first name, or organization name of the provider.
Item 3	Enter the Medicaid Provider ID
Item 4	Enter the National Provider Identifier (NPI) of the provider.

Item 5

Select the type of provider going through an audit or investigation using the list below.

Addiction Services	Physician – Allergist	Physician - Orthopedic Surgeon
Advanced Practice Nurse	Physician – Anesthesiologist	Physician – Otologist, Laryngologist, Rhinologist
Ambulatory Surgical Center	Physician – Cardiologist	Physician - Pathologist
Audiologist	Physician - Cardiovascular Surgeon	Physician - Pediatric Surgeon
Chiropractor	Physician – Dermatologist	Physician - Physical Medicine & Rehab
Clinic	Physician - Emergency Medicine	Physician - Plastic Surgeon
Dentist	Physician - Family Practitioner	Physician - Proctologist
Durable Medical Equipment	Physician – Gastroenterologist	Physician - Psychiatrist
ESRD Clinic	Physician – General Internist	Physician - Pulmonary Disease Specialist
Extended Care Facility	Physician - General Pediatrician	Physician - Radiologist
Genetic Counselor	Physician - General Practitioner	Physician - Thoracic Surgeon
Hearing Aid Dealer	Physician - General Surgeon	Physician - Urologist

Home Health Agency	Physician – Hand Surgeon	Physician Assistant
Hospice	Physician – Neonatologist	Podiatrist
Hospital	Physician - Neurologist	Public Health Agency
Laboratory	Physician – Nephrologist	Radiology
Mental Health Provider	Physician - Nuclear Medicine Practitioner	Rehabilitation Facility
Optometrist	Physician - OB/GYN	School Corporation
Optician	Physician - Oncologist	Therapist
Pharmacy	Physician – Ophthalmologist	Transportation
Other		

Item 6

Select the source of the complaint from the list below.

Source of the Complaint:
Data Mining
External Vendor
Internal
Law Enforcement
Member
News/Media
Provider
Public
Referral from Other Source
State Agency Referral
Whistleblower

Enter the complaint source.

<table>
<tr><td>Item 7</td><td>Choose up to three from the list below to describe the nature of the complaint.
<table>
<tr><th>Allegation:</th></tr>
<tr><td>Billing Member</td></tr>
<tr><td>Billing for Services Not Rendered</td></tr>
<tr><td>Changing Dates of Service</td></tr>
<tr><td>Double-Billing</td></tr>
<tr><td>Drug Diversion</td></tr>
<tr><td>Failure to Disclose Relationship</td></tr>
<tr><td>False Claims</td></tr>
<tr><td>Illegal Solicitation</td></tr>
<tr><td>Incorrect Diagnosis or DRG Coding</td></tr>
<tr><td>Incorrect Modifier Usage</td></tr>
<tr><td>Incorrect Number of Days/Visits/Treatments</td></tr>
<tr><td>Not Medically Necessary: experimental or investigational</td></tr>
<tr><td>Overutilization</td></tr>
<tr><td>Pharmacy Fraud</td></tr>
<tr><td>Prescribing Practices</td></tr>
<tr><td>Questioned Documents (altered, forged, falsified)</td></tr>
<tr><td>Sanctioned</td></tr>
<tr><td>Services Not Authorized</td></tr>
<tr><td>Third Party Liability (other insurance, worker’s comp, auto injury, product liability)</td></tr>
<tr><td>Unbundling</td></tr>
<tr><td>Unqualified Provider to Perform Services</td></tr>
<tr><td>Upcoding</td></tr>
<tr><td>Quality</td></tr>
</table></td></tr>
<tr><td>Item 8</td><td>Enter the total amount of dollars identified prior to the audit/investigation.</td></tr>
<tr><td>Item 9</td><td>Enter the final total dollar amount of overpayment recovered. If unknown leave blank.</td></tr>
<tr><td>Item 10</td><td>Enter the date the fraud, waste, or abuse referral was submitted to OMPP PI.</td></tr>
<tr><td>Item 11</td><td>Enter the status or update of the submitted case. (If applicable.)</td></tr>
<tr><td>Item 12</td><td>Enter the date the case is closed by the MCE.</td></tr>
</table>

Report Number	**1102**
Report Title	**Report 1102: Program Integrity Payment Suspension Report**
Purpose	The MCEs will report all providers on payment suspension for a determined credible allegation of fraud. The reported information will be assessed by the OMPP PI Unit to ensure the MCEs have initiated payment suspension as a result of a determined credible allegation of fraud by the Program Integrity Provider Review Committee (PIPRC).
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lines of Business to Report	HHW, HIP and HCC combined
Qualifications/ Definitions	This is a quarterly report. The MCE must submit the report to OMPP by the last day of the month following the end of the reporting period. This report is required for all three programs: HCC, HHW, and HIP. All programs are to be reported cumulatively; only ONE report is requested from the MCEs. Please place the file on SharePoint under the HIP folder. This report must include program integrity actions taken by the MCE and all subcontractor delegated entities such as transportation, pharmacy, vision, mental health, and dental vendors.
Item 1	MCEs may utilize this field for additional identifying information, such as an internal case tracking number.
Item 2	Enter the last name, first name, or organization name of the provider.
Item 3	Enter the Medicaid Provider ID
Item 4	Enter the National Provider Identifier (NPI) of the provider.
Item 5	Enter the date the provider payment suspension was successfully implemented within MCE's payment system.
Item 6	Enter the reason for the provider payment suspension.
Item 7	Enter the date the payment suspension was lifted.
Item 8	Enter the reason the payment suspension was lifted.

Report Number	**1103**
Report Title	**Report 1103: Program Integrity Prepayment Review Report**
Purpose	The MCEs will report provider information on all providers currently evaluated through prepayment review. Reported information will include quarterly updates on the most recent provider accuracy rate as determined by the MCE.
Format	OMPP Excel template
Periodicity of Submission	Quarterly
Lines of Business to Report	HHW, HIP and HCC combined
Qualifications/ Definitions	This is a quarterly report. The reporting period is every three months (i.e., Jan-Mar, April-June, July-Sept, Oct-Dec). The MCE must submit the report to OMPP by the last day of the month following the end of the reporting period. This report is required for all three programs: HCC, HHW, and HIP. All programs are to be reported cumulatively; only ONE report is requested from the MCEs. Please place the file on SharePoint under the HIP folder. This report covers the prepayment review program integrity actions taken by the MCE and all subcontractor delegated entities such as transportation, pharmacy, vision, mental health, and dental vendors.
Item 1	MCEs may utilize this field for additional information, such as a case tracking number, or other information as needed by the MCE.
Item 2	Enter the last name, first name, or organization name of the provider on the prepayment review.
Item 3	Enter the Medicaid Provider ID
Item 4	Enter the National Provider Identifier (NPI) of the provider currently being monitored through PPR
Item 5	Enter the Tax Identification Number (TIN) of the provider for whom PPR was initiated.

Item 6

Use list below to select the provider type of the provider placed on PPR.

Addiction Services	Physician – Allergist	Physician - Orthopedic Surgeon
Advanced Practice Nurse	Physician – Anesthesiologist	Physician – Otologist, Laryngologist, Rhinologist
Ambulatory Surgical Center	Physician – Cardiologist	Physician - Pathologist
Audiologist	Physician - Cardiovascular Surgeon	Physician - Pediatric Surgeon
Chiropractor	Physician – Dermatologist	Physician - Physical Medicine & Rehab
Clinic	Physician - Emergency Medicine	Physician - Plastic Surgeon
Dentist	Physician - Family Practitioner	Physician - Proctologist
Durable Medical Equipment	Physician – Gastroenterologist	Physician - Psychiatrist
ESRD Clinic	Physician – General Internist	Physician - Pulmonary Disease Specialist
Extended Care Facility	Physician - General Pediatrician	Physician - Radiologist
Genetic Counselor	Physician - General Practitioner	Physician - Thoracic Surgeon
Hearing Aid Dealer	Physician - General Surgeon	Physician - Urologist

<table>
<tr><td></td><td>
<table>
<tr><td>Home Health Agency</td><td>Physician – Hand Surgeon</td><td>Physician Assistant</td></tr>
<tr><td>Hospice</td><td>Physician – Neonatologist</td><td>Podiatrist</td></tr>
<tr><td>Hospital</td><td>Physician - Neurologist</td><td>Public Health Agency</td></tr>
<tr><td>Laboratory</td><td>Physician – Nephrologist</td><td>Radiology</td></tr>
<tr><td>Mental Health Provider</td><td>Physician - Nuclear Medicine Practitioner</td><td>Rehabilitation Facility</td></tr>
<tr><td>Optometrist</td><td>Physician - OB/GYN</td><td>School Corporation</td></tr>
<tr><td>Optician</td><td>Physician - Oncologist</td><td>Therapist</td></tr>
<tr><td>Pharmacy</td><td>Physician – Ophthalmologist</td><td>Transportation</td></tr>
</table>
</td></tr>
<tr><td>Item 7</td><td>Enter the effective date of the PPR as indicated on the notification sent to the provider.
Enter date in MM/DD/YY format.</td></tr>
<tr><td>Item 8</td><td>List up to three (3) reason(s) [primary, secondary, and tertiary] the MCE chose to place the provider on PPR from the list below.
- Billing Member
- Billing for Services Not Rendered
- Changing Dates of Service
- Double-Billing
- False Claims
- Illegal Solicitation
- Incorrect Diagnosis or DRG Coding
- Incorrect Modifier Usage
- Incorrect Number of Days/Visits/Treatments
- Over-utilization
- Poor Documentation
- Upcoding
- Re-enforce Education
- Prescribing Practices</td></tr>
</table>

	- Questionable Documents - Following State Action - Services Not Authorized: no prior approval (PA), service not covered by Medicaid, or lacking patient consent - Unbundling
Item 9	Enter the Affected codes
Item 10	Enter the total count of last review cycle claims. Review cycle is 90 days.
Item 11	Enter the total count of last review cycle claims approved. Review cycle is 90 days.
Item 12	Enter the last review cycle accuracy rate (%). Review cycle is 90 days.
Item 13	Enter the previous cycle accuracy rate (%)
Item 14	Enter the date that PPR ended. Enter date in MM/DD/YY format.
Item 15	Enter the reason PPR was lifted for this provider.

Report Number	**1104**
Report Title	**Report 1104: Annual Program Integrity Plan Report**
Purpose	To identify and monitor the high-level primary work plan goals the MCE has set to address program integrity (PI) compliance. The plan will include a detailed description of the planned activities to identify, investigate, and resolve fraud, waste, and abuse issues of MCE providers, vendors, and subcontractors.
Format	MCE format
Periodicity of Submission	Annually
Data Reported Each Submission	January 31
Lines of Business to Report	HHW, HIP and HCC combined
Qualifications/ Definitions	This Plan should be submitted annually and upon request by the OMPP Program Integrity (PI) Unit, and updated quarterly or more frequently if required by the OMPP PI Unit. The Annual Program Integrity Plan shall serve as the MCE's compliance plan and contain a prospective plan and a retrospective evaluation of the prior year's activities. **Annual Plan - Prospective:** The report includes the mandatory requirements for the prospective goals and a detailed description of the planned activities, along with documentation of the routine methods for ongoing referrals and MCE initiatives that support program integrity compliance. The PI Plan should contain information specific to Indiana and contain each of the elements listed below. **Annual Evaluation - Retrospective:** In the annual evaluation, the MCE must review its PI plan and provide OMPP with the final status of goals previously set. The retrospective evaluation is due to OMPP by January 31st of each calendar year. The prospective plan and retrospective evaluation may be a combined document if the report clearly separates the required material. **Reporting Submission Example:** January 31st 2022 – Prospective 2022 PI Plan due

	January 31st 2022– Retrospective 2021 PI Plan Evaluation due
Element 1	Establishing and maintaining written policies for identification, investigation, and resolution of waste fraud and abuse issues of MCE providers, vendors, and subcontractors (including but not limited to Pharmacy Benefits Managers, vision, transportation, dental, and MCE itself
Element 2	Standards of conduct and commitment to comply with all applicable state and federal standards
Element 3	Designation of a Special Investigation Unit Manager, a Compliance Officer, and a Compliance Committee
Element 4	Documentation that the Compliance Officer and SIU Manager shall meet with the OMPP PI Unit at a minimum of quarterly and as directed by the OMPP PI Unit.
Element 5	Type and frequency of training and education for the SIU Manager, compliance officer, and employees provided to detect fraud.
Element 6	Training must be annual and address False Claims Act, Indiana laws and requirements government Medicaid reimbursement and utilization of services – particularly changes in rules, and other federal and state laws governing Medicaid provider participation and payment as directed by the CMS and FSSA. Training should also focus on recent changes in rules.
Element 7	A risk assessment of the MCE's various fraud and abuse/program integrity processes. A risk assessment shall also be submitted on an 'as needed' basis and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment and fines), is issued on a provider with concerns of fraud and abuse. The MCE shall inform the OMPP PI Unit of such action and provide details of such financial action. The assessment shall also include a listing of the MCE's top three vulnerable areas and shall outline action plans mitigating such risks.
Element 8	Organizational chart and communication plan highlighting lines of communication between the Special Investigations Unit Manager, Compliance Officer, and employees.
Element 9	Provision for internal monitoring and auditing
Element 10	Descriptions of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to a list of: • Goals, objectives, and planned activities for the upcoming year • Automated pre-payment claims edits • Automated post-payment claims edits • Types of desk audits on post processing review of claims • Reports for provider profiling and credentialing used to aid program and payment integrity reviews • Surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services

	• Provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials • References in provider and member material regarding fraud and abuse referrals • Provisions for the confidential reporting of PI Plan violations to the designated person • Provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance reports • Provisions ensuring that the identities of individuals reporting violations of the Contractor are reported and that there is no retaliation against such persons • Specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting and investigating fraud and abuse compliance PI Plan violations • Reporting requirements – of any confirmed or suspected provider fraud and abuse under state or federal law to the OMPP PI Unit and pursuant to the Program Integrity Operations section of the HHW and HIP MCE Policies and Procedure Manual. • Retaliation – assurances that no individual who reports MCE's potential violations or suspected fraud and abuse is retaliated against • Site visits – policies and procedures for conducting announced and unannounced site visits and field audits to providers defined as high risk (including but not limited to providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly Response to detected offenses, and for development of corrective action initiatives

Report Number	**1202 and 1203**
Report Title	**Report 1202 and 1203: Reimbursement for FQHC and RHC Services (Detail and Summary)**
Purpose	Identify encounters, performance incentives and payments made to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) by the MCEs in order to identify any supplemental payments that may be required of the State to remit to the FQHC or RHC.
Format	Excel template This template is separately provided from the routine reporting workbook due to its annual submission. There are separate templates for HHW/HCC and HIP due to the differences in packages and claims lag period.
Periodicity of Submission	Annually
Data Reported Each Submission	Due 45 days after the end of the reporting period
Lines of Business to Report	HHW, HIP and HCC combined
Qualifications/ Definitions	• "For Hoosier Healthwise and Hoosier Care Connect, the reporting period includes a full calendar year and a twelve-month claims lag period as data is submitted on an incurred basis. • For the Healthy Indiana Plan (HIP), the reporting period includes a full calendar year and does not include a claims lag period as data is submitted on a paid basis. FQHCs and RHCs receive reimbursement for the services rendered equal to the amount the provider is entitled under the Benefits Improvement and Protection Act of 2000 (BIPA) utilizing a prospective payment system (PPS) methodology. Therefore, payments must be reviewed by the rate-setting vendor per BIPA allowances. Submitted reports should collate data related to administrative, capitation, and/ or fee for service payments made by the MCE to the FQHC or RHC. This is to include delegated activities, such as applicable MBHO encounters and payments. Any claim for which payment is made should be captured. For claims with multiple claim detail lines, claim detail line information is to be reported on separate lines of the report. • For Hoosier Healthwise and Hoosier Care Connect, all claims that are dispositioned to a paid status are to be included. This should consist of the final paid/adjudicated claim lines only.

	• For the Healthy Indiana Plan, all claims that are dispositioned to a paid status are to be included. Additionally, for any claims that are adjusted, the claims data reported should consist of the entire claim line history (i.e. the original claim, the voided claim, and the replacement claim, if applicable). If a claim is dispositioned to a "denied" status due to a third party liability (TPL) payment on the claim is greater than the MCE allowable amount, include these services. If an MCE includes denied claims due to TPL, the MCE must provide a list of applicable TPL explanation of benefit codes with a description as an attachment to the AN-FQHC submission. The excel template provided includes: (1) a summary worksheet tab with total expenditures by expenditure type • Total dollars paid for fee-for-service claims • Total dollars paid for performance incentives • Total dollars paid as capitation payments • Total dollars paid as administration fees (2) a detailed claims worksheet tab to report all claim details regardless if it was paid fee-for-service or received as shadow data for which the provider was paid a capitation. HHW and HIP templates contain different tabs due to the inclusion of various applicable coverage packages. **<u>The MCE should submit separate Excel workbooks for each FQHC/RHC provider.</u>** On an on-going basis, the rate-setting contractor will provide to the Compliance Officer for each MCE an updated FQHC and RHC provider file list for which data must be submitted. In addition, the rate-setting contractor will provide a summary of the received "supplemental wrap payment requests" from these providers to date. This data is expected to be shared June of each year. An example of this data is included in the Appendix. FQHC/RHC providers may be identified utilizing the Provider table provided to the MCE monthly by the fiscal agent in conjunction with the data provided by the rate-setting contractor.

	OMPP reserves the right to audit the data submitted in this report.
Item 1	Indicate the name of the FQHC or RHC on which the MCE is reporting.
Item 2	Insert the FQHC/RHC Indiana Health Coverage Program's (IHCP) provider identification number for the FQHC or RHC provider identified in Item 1, "FQHC/RHC Provider Name."
Item 3	Insert the FQHC/RHC NPI number for the FQHC or RHC provider identified in Item 1, "FQHC/RHC Provider Name."
Item 4	Indicate if the MCE maintained a contract with the provider identified in Item 1 at any time during the reporting period. Enter the applicable response.
Item 5	Indicate if the MCE maintained a contract that was based on a capitated payment arrangement at any time during the reporting time period. If the MCE maintained both a capitated and fee-for-service arrangement at any time during the reporting period, ALL claims are to be reported according to the excel template and report specifications. Enter the applicable response.
Item 6	Indicate the beginning date of the reporting period for which the MCE is submitting the report. Base the reporting period on the applicable reporting "incurred" dates of services period. Enter in MM/DD/YYYY format.
Item 7	Indicate the ending date of the reporting period for which the MCE is submitting the report. Base the reporting period on the requested "incurred" dates of service period. Enter in MM/DD/YYYY format.
Item 8	Indicate the paid date period for the beginning and ending reporting period or claims lag period, as appropriate. Enter in MM/DD/YYYY format.
Item 9	On the Summary Tab, identify the total dollar amount "paid" to the provider as fee-for-service claims during each month separately for the reporting period. Enter dollar amount in $XXX,XXX.xx format. If there were no fee-for-service claims paid during the month, leave this field blank
Item 10	On the Summary tab, identify the total dollar amount paid for performance incentives during each month of the reporting period. This amount should **not** include administrative fees or dollars reimbursed for fee-for-service or capitated services. Enter dollar amount in $XXX,XXX.xx format. If there were no performance incentives paid during the month, leave this field blank.

Item 11	On the Summary tab, indicate the monthly capitation payments from the MCE to the FQHC/RHC during the reporting period. This number should **not** include any performance incentives paid during each month of the reporting period or any amount paid as fee-for-service. Enter dollar amount in $XXX,XXX.xx format. If there were no capitation payments made or if the MCE's reimbursement arrangement to the FQHC/RHC does not include capitation, leave this field blank.
Item 12	On the Summary tab, indicate the monthly administrative fees paid from the MCE to the FQHC/ RHC during the reporting period. Enter dollar amount in $XXX,XXX.xx format. If there were no administrative fees paid or if the MCE's reimbursement arrangement to the FQHC/RHC does not include administrative fees, leave this field blank.
Item 13	On the Detail tab, consecutively number each row for the report that has claim information. Enter a consecutive number beginning with number 1 with the first claim's detail line.
Item 14	Indicate the claim type. Use "1" for medical and behavioral health claims, "2" for dental claims, and "3" for pharmacy claims.
Item 15	Indicate the member's first name as listed on the referenced claim item.
Item 16	Indicate the member's last name as listed on the referenced claim item.
Item 17	Insert the member's Medicaid recipient identification number (RID) that is associated with the reported claim
Item 18	Identify the MCE claim number being submitted for the report. This should be the MCE internal claim number as listed within the MCE system and indicated on the shadow claim in the patient account number field.
Item 19	Insert the numeric detail line number of the claim.
Item 20	For medical, behavioral health, and dental claims, indicate the date the identified member received the service that is being reported on the claim. For pharmacy claims, leave this field blank. Enter in MM/DD/YYYY format.
Item 21	For pharmacy claims, indicate the date the prescription was prescribed by the physician. For medical, behavioral health, and dental claims, leave this field blank. Enter in MM/DD/YYYY format.
Item 22	For pharmacy claims, indicate the date the prescription was dispensed. For medical, behavioral health, and dental claims, leave this field blank. Enter in MM/DD/YYYY format.

<table>
<tr><td>Item 23</td><td>Indicate the date the submitted claim was adjudicated as “paid” by the MCE to the FQHC or RHC.
If the claim was adjudicated to a denied disposition solely due to the fact that the applicable third party liability was greater than the MCE allowed amount, enter the date the adjudication occurred.
Enter in MM/DD/YYYY format.</td></tr>
<tr><td>Item 24</td><td>Explain any benefits (i.e., Explanation of Benefits) using the additional columns as necessary to identify more than one benefit. Limit explanation to 200 alpha/numeric characters Enter in $XXX,XXX.xx format.</td></tr>
<tr><td>Item 25</td><td>Indicate the billed amount of the detail line number of the claim.
Enter in $XXX,XXX.xx format..</td></tr>
<tr><td>Item 26</td><td>Indicate the paid amount of the detail line number of the claim. This should not include any incentive payment, only the fee schedule claim payment.
If the amount paid was zero due to a third party liability payment, enter $00.00.
Enter in $XXX,XXX.xx format.</td></tr>
<tr><td>Item 27</td><td>Indicate the paid amount of the detail line number of the claim.
Enter in $XXX,XXX.xx format.</td></tr>
<tr><td>Item 28</td><td>Insert the place of service numeric code as appropriate. If “Other, identify” provide a description, limited to 25 alpha/numeric characters. <u>Place of Service Codes:</u>
<table><tr><td>Ambulance</td><td>41</td></tr><tr><td>Ambulatory Surgical Center</td><td>24</td></tr><tr><td>Birthing Center</td><td>25</td></tr><tr><td>Emergency Room - Hospital</td><td>23</td></tr><tr><td>Federally Qualified Health Center</td><td>50</td></tr><tr><td>Home</td><td>12</td></tr><tr><td>Inpatient Hospital</td><td>21</td></tr><tr><td>Laboratory</td><td>81</td></tr></table></td></tr>
</table>

		Nursing Facility	32
		Office	11
		Other, identify	99
		Outpatient Hospital	22
		Rehabilitation Facility - Inpatient	61
		Rehabilitation Facility – Outpatient	62
		Rural Health Clinic	72
		Skilled Nursing Facility	31
		Urgent Care Facility	20
Item 29	For medical, behavioral health, and dental claims, insert the procedure code as listed for the detail line number on the claim. For pharmacy claims, leave this field blank.		
Item 30	For medical, behavioral health and dental claims insert the HCPCS modifiers for the detail line number of the claim using additional columns as necessary for additional modifiers as listed on the claim. For pharmacy claims, leave this field blank.		
Item 31	For medical and behavioral health claims, insert the primary diagnosis code for the detail line number of the claim using additional columns as necessary for secondary diagnosis codes as listed on the claim. For pharmacy and dental claims, leave this field blank.		
Item 32	For medical, behavioral health, and dental claims, identify the first name of the rendering provider as listed on the claim. For pharmacy claims, leave this field blank.		
Item 33	For medical, behavioral health, and dental claims, identify the last name of the rendering provider as listed on the claims. For pharmacy claims, leave this field blank.		
Item 34	For medical, behavioral health, and dental claims, enter the National Provider Identifier (NPI) number for the rendering provider. For pharmacy claims, leave this field blank.		
Item 35	Enter any performance incentive payments that are paid on a claim level. These amounts should be excluded from Item 8 above. Do not include performance incentive payments that are not paid on a claim level.		
Item 36	For dental claims, enter the emergency indicator. For medical, behavioral health, and pharmacy claims, leave this field blank. Enter in “Y” or “N” format		

Item 37	For each detail line, insert the billing NPI number from the claim. The billing NPI number should agree to the NPI number reported in Item 3.