ATTACHMENT 12

REPORTING PACKAGE

Vital
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GOBIERNO DE PUERTO RICO

Plan Vital Reporting Guide

V.08.2021

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19 - 053

ASES

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The current version of this document is posted at:

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Document Revision History

VERSION#	DATE	SUMMARY OF AMENDMENT
V.01.2019	3/18/2019	Initial draft.
V.02.2019	5/3/2019	Updates for XML locations (Guide, Reports 20, 27). Reconciliation with excel templates.
V.03.2019	6/1/2019	Revised Report 8.
V.04.2019	12/4/2019	Revised report timeframes including annual report submission requirements. Certain requirements for Reports 1, 3, 16 and 21 were revised.
V.05.2020	6/15/2020	Revised XML report number references, updated reporting validations, revised Report 11 requirements.
V.06.2020	10/15/2020	Revised Report 6, 7, 8, 16, 17, 22, 31
V.07.2021	4/15/2021	Several improvements and enhancements on reporting validations and rules. Addition of Appendix 3 – Provider Specialty Code List. Revised Report 3, 6, 9, 15, 16, 17, 19, 20, 22, and 24.
V.08.2021	7/7/2021	Several improvements and enhancements on reporting validations and rules. Revised Report 3, 11, 15, 17, 21 and 24.

General Information
Introduction

This Reporting Guide (Guide) includes specifications, outlining bi-monthly, monthly, quarterly, semi-annual and annual reporting requirements, for Medicaid managed care organizations (Contractors) contracted with ASES. Guide requirements apply to populations defined under Section 1.3 of the contract.

Technical specifications are outlined for the required reports as distributed in Attachment 16 of the November 1, 2018 contract. This Guide is paired with accompanying XML Schema Definition (XSD) templates for submission of data in XML.

In the Reports Specification section below, reports are listed in line with Attachment 16 and section 18.2 of the contract. The Annual Plans section is in line with 18.3 of the contract.

This Guide does not include specifications for the Health Care Initiative Program (HCIP) reporting requirements, as there is a specific reporting guide for the HCIP. Similarly, instructions for reports High Cost High Need (HCHN) and Encounter data (CLM) using SOP and layout specification, respectively.

Data submitted as specified will be used by ASES to monitor quality, access, timeliness and care management aspects of operations of the Contractor. This Guide serves as the data dictionary/codebook containing definitions and elements of each performance metric.

General Instructions

All required report data must be submitted via the accompanying data submission XSD templates (as specified) and respective field requirements to generate the XML file. When variance is noted indicating need for improvement or a significant change, Contractors should use the specific section provided for this purpose (Notes/Comments) to include a description for the variance and corrective action steps to remediate the finding.

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If ASES asks for an updated report, such report must be sent with the specific nomenclature (frequency, version) for the associated report.

When the report includes a detail and a summary area, the MCO must verify the accuracy of the report validating that the sum corresponds to the detailed data submitted.

Additional technical instructions or assistance will be supplied by ASES when required.

Structure to the Reporting Guide
This Guide contains parameters and specifications for all reports listed in Attachment 16 of the contract. Each report section includes a link to XML Schema Definition (XSD), a description of the purpose of the report, the submission requirement(s) and detailed specifications for each parameter. **Note all specifications detailed in this guide, supersede specifications issued in prior report templates or instructions.**

Where applicable, the parameter and specifications tables below provide detailed information on specific data lines, formulas and references. Each parameter and specifications section includes the following sections:

The PARAMETER column lists the parameter or measure to be reported. The DEFINITION AND SPECIFICATION column provides the definition and any specifications for the parameter. In cases where there is an applicable formula, calculation or contract standard. The information is provided under the specification for the parameter.

PARAMETER	DEFINITION AND SPECIFICATION
Calls Received	For each service line, the total number of calls received for the service line (e.g., all calls answered plus abandoned calls) during the reporting period.
Abandoned Calls	For each service line, the number of calls that were initiated to the call center but ended before being answered by a live voice or accessing a caller-selected option.
Abandoned Calls %	**Definition:** For each service line, the percentage of calls received that were abandoned. No data entry required. **Contract Standard:** = < 5% **Formula:** Abandoned calls divided by Calls Received.

Reports have multiple data categories being reported. The dark grey row indicates a new data category of the report. In the example below, the call center report has two data categories (1.A Call Center Statistics and 1.B Staffing). Certain reports also include sub-sections within a specific data category; these sub-sections are distinguished as “Section 1”, “Section 2” throughout this guide.

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PARAMETER	DEFINITION AND SPECIFICATION
1.A Call Center Statistics	
Parameter	Definition and specification
1.B Staffing	
Parameter	Definition and specification

Updates and Amendments to the Reporting Guide
This Guide is subject to amendments and updates at the discretion of ASES. At a minimum, ASES will review and update the guide during the report development process and when (i) a contract amendment is made, (ii) ASES decides to add a recurring additional report pursuant to section 18.1.1 of the Contract, and (iii) ASES makes any changes to existing reports pursuant to section 18.1.6 of the Contract.

The history of changes made to the Guide will be tracked and provided by the version number indicated on this Guide. ASES will maintain the most up to date Guide and will distribute to the Contractors as required. The most up to date Guide will be made available at:

https://ases.securevdr.com

Folders > Guias_y_Plantillas_Reportes

Submission Requirements
The Contractor must submit all reports electronically, using the templates provided (where applicable) and the XML data layout, without alteration. The Contractor must submit Plan Vital reports to ASES's secure FTP site, unless otherwise directed by ASES.

The Contractor must comply with HIPAA and Federal regulations when transmitting data to ASES. The date of receipt of the electronic version will serve as the date of receipt for the report(s) (see section 18.1.16 of the Contract).

The Contractor is required to only update reports that are relevant to the period being reported.

For templates that include an Analysis/Narrative/Notes section(s), ASES requires, in no prescribed format, that the narrative notes provide pertinent information to that specific report, including explanation of any abnormalities within the reported data or reasons for unusual increases or decreases, as applicable to each of the reports. Providing comprehensive notes will limit any necessary follow-up inquiries with the Contractor. If necessary, please attach any additional documentation referencing the applicable reports as a means of providing further explanation.

Timeliness
All reports must be complete and submitted to ASES by the due dates outlined in the Contract and stated in this Guide.

Extensions to report submission dates will be considered by ASES after the Contractor has contacted the ASES designated point of contact via email at least twenty-four (24) hours in advance of the report due date. Extension for submission of reports should be under rare and unusual circumstances. If ASES grants an extension, and the report is submitted before the extended deadline, the report(s) will be considered timely and not subject to penalty. Not requesting an extension at least twenty-four (24) hours of the report due date is considered failure to report timely.

The Contractor must submit all reports to ASES, unless indicated otherwise in the Contract, according to the schedule below:

Reporting Due Dates			
Reporting Period			
Weekly Reports	Friday of the following Week.		
Bi-Weekly Reports	Due two days after the two weeks' period. The report should reflect the previous two-week period.		
Monthly Reports	Fifteenth (15th) Calendar Day of the following month.		
Quarterly Reports	Thirtieth (30th) Calendar Day of the following month.		
Reporting Quarters	**Year 1**	**Year 2**	**Year 3**
Q1	11/01/2018 - 12/31/2018	10/01/2019 - 12/31/2019	10/01/2020 - 12/31/2020
Q2	01/01/2019 - 03/31/2019	01/01/2020 - 03/31/2020	01/01/2021 - 03/31/2021
Q3	04/01/2019 - 06/30/2019	04/01/2020 - 06/30/2020	04/01/2021 - 06/30/2021
Q4	07/01/2019 - 09/30/2019	07/01/2020 - 09/30/2020	07/01/2021 - 09/30/2021

Unless otherwise directed in the report-specific instructions, prior period information should be refreshed, where applicable, if the results vary materially from the information previously reported. Pay particular attention to the instructions for reports where the data is based on claims information as the requirements may vary across relevant reports.

Bi-weekly Report Submission Due Dates
For the PHACER bi-weekly report, the period of each bi-week was reviewed and confirmed with the Finance department, where each period begins on a Thursday and ends on Wednesday two weeks later.

Annual Report Submission Due Dates
Due dates for Annual reports vary by report, see the table below for due dates for each annual submission.

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Annual Report Period Definitions:

Year	Plan Vital Contract Year (PVCY)	Puerto Rico Fiscal Year (PRFY)	Federal Fiscal Year (FFY)	Calendar Year (CY)
1	November 1, 2018* to October 31, 2019	November 1, 2018* to June 30, 2019	November 1, 2018* to September 30, 2019	November 1, 2018* to December 31, 2019
2	November 1, 2019 to June 30, 2020	July 1, 2019 to June 30, 2020	October 1, 2019 to September 30, 2020	January 1, 2020 to December 31, 2020
3	July 1, 2020 to September 30, 2021	July 1, 2020 to June 30, 2021	October 1, 2020 to September 30, 2021	January 1, 2021 to December 31, 2021

*Adjusted to reflect the starting date of the Plan Vital contract

Annual Reporting Periods and Due Dates:

Report Number	Report Title	Reporting Period	Report Due Date
9	Disclosure of Information on Annual Business Transactions	Plan Vital contract year	90 days after the end of the Plan Vital contract year.
10	Annual Statistical Report	PRFY	45 days after the end of the Puerto Rico Government fiscal year.
13	CMS-416 Report - EPSDT	FFY	March 1st of the following year.
18	Provider Satisfaction Survey Report	CY	7 months after the end of the calendar year.
20	Physician Incentive Report	CY	90 days after the end of the calendar year.
23	Enrollee Satisfaction Survey Report	CY	7 months after the end of the calendar year.
24	Audited HEDIS Results Report	CY	7 months after the end of the calendar year.
27	Business Continuity and Disaster Recovery (BC-DR) Test Report	Plan Vital contract year	90 days after the end of the Plan Vital contract year.
29	Report on Controls Placed in Operation and Tests of Operating Effectiveness (SSA E 16)	Plan Vital contract year	90 days after the end of the Plan Vital contract year.
30	Audited Financial Statements	Based on contractor's FY	90 days after the closing of the contractor's FY.
32	Report to Puerto Rico Insurance Commissioner's Office	CY	March 31st of the following year.
33	Annual Corporate Report	Based on contractor's FY	90 days after the closing of the contractor's FY.

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If a report due date falls on a weekend or a Puerto Rico holiday, receipt of the report the next business day is acceptable (see Section 18.1.13 of the Contract).

Data Fields

The Contractor shall report the following data elements using the following data formats, unless specified otherwise in the relevant report sections:

Field	Data Format
Date	The acceptable format for dates is YYYYMMDD. For example: January 1, 2020 would be entered: 20200101
Hours and Minutes	The acceptable format is an hour number and fraction rounded to fifteen minutes. For example: 7 hours and 15 minutes = 7.25 and 7 hours and 30 minutes = 7.50 Only fractions of .00, .25, .50, and .75 are acceptable for minutes. This is applicable to all reports with exception to: Report 1 – Call Center.
Dollar Amounts	The acceptable format for dollar amount is a value with two decimal places.
Municipality Code	The two-digit code associated with each municipality in Puerto Rico. Refer to the list of municipality codes of the Carrier to ASES Data Submissions-New File Layouts-Version 4.0B.
MPI	The Master Patient Index (MPI) number of an enrollee is a unique 13-digits numeric assigned by Puerto Rico Department of Medicaid to enrolled beneficiaries and it is supplied by the ASES Eligibility Data for Vital Plan.
NPI for Individual Practitioners	The National Provider Identifier (NPI) is a unique 10-digit number as issued by the CMS National Plan and Provider Enumeration System (NPPES).
NPI for Primary Medical Group (PMG)	The National Provider Identifier (NPI) is a unique 10-digit number as issued by the CMS National Plan and Provider Enumeration System (NPPES). This is an optional field for PMGs without a valid NPI, leave this field blank.
PMG ID #	Enter the PMG ID Number in text format. This is a code assigned by Carrier.
Federal Tax ID or EIN or SSN	Must be a full 9 digits in length, right justified, zero filled. Numeric format.
Provider Specialty Code	Refer to list of references associated to Appendix 3 of this Guide.
Yes / No	The valid options are Y or N
Yes / No / NA	The valid options are Y, N or NA

Fields must not be blank or empty if the optional rule is not specified. Quantity fields must be zero when no data is reported.

List of references for standard values

All reports must use the ASES_types.xsd that contains the standards list of references associated with each report.

ASES Enterprise System Rule Validation

The ASES Enterprise System (ES) validates all report submissions upon receipt from Contractors. Contractors must ensure their reporting systems are up-to-date with the current Guide and all specifications and Submission Requirements are followed. The Contractor must closely evaluate each parameter specification and the associated "Formula", "Data Format" and "Rule Validations" associated with certain parameters.

In the event a report is not submitted in a required format, does not follow required specifications, or is not consistent with certain "Formula" calculations and or "Rule Validations" requirements as specified, a report may automatically be denied by ES.

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Format and Delivery

The Contractor shall submit all reports electronically, using the templates provided (where applicable) and the XML data layout, without alteration. The Contractor shall submit Plan Vital reports to ASES's secure FTP site, unless otherwise directed by ASES.

Excel or PDF files must be delivered to the following file location: The .xlsx or.pdf associated to each report must be placed in the respective Citrix Share folder according to its frequency and department located in the root directory "Directorio para reportes" for each MCO.

XML data files must be delivered to the file location explained at the beginning of each report specifications. The XML file associated to each report must be placed in the respective Citrix Share folder according to its frequency and department located in the root directory "Directorio para reportes" for each MCO. Other locations will not be accepted. The XML standard encoding is UTF-8.

1. Nomenclature for Excel-based Report

The following report: 13. CMS-416 Report – EPSDT is the only one report that must be submitted in Excel format following the specific CMS requirement explained in the respective report specification below.

This Excel file must be submitted using the following nomenclature: RP_CC_ID_YYYYMMR.XLSX. Please refer to the associated explanation fields on the table below.

XML File Nomenclature	Monthly, Quarterly, Annually Bi-Weekly	RP_CC_ID_YYYYMMR.XML RP_CC_ID_YYYYMMDDR.XML
Field	**Description**	
RP	Abbreviation of Reporting Package (constant)	
CC	Carrier ID 09 FMHP (First Medical MCO) 10 MMM (MMM MCO) 12 PSM (Plan Menonita MCO) 13 SSS (Triple S MCO)	
ID	Report Number (ID) assigned (Attachment 16).	
YYYY	Year reported.	
MM	Month reported.	
DD	Day Reported (Bi-weekly reports)	
R	Document version number. 0 If it is the first time you submit it. 1 If it is the second time you submit it and so on.	

Example: The National Provider List (NPL) file nomenclature to be processed is identifying as follow: e.g., RP_09_15_2018010.XML (This is a demo)

2. Nomenclature for PDF Reports

There are some reports that are required in PDF formats. The nomenclature for these PDF reports must be submitted as follows:

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Nomenclature for PDF Reports	Monthly, Quarterly, Annually Bi-Weekly	RP_CC_ID_YYYYMMR.PDF RP_CC_ID_YYYYMMDDR.PDF

Field	Description
RP	Abbreviation of Reporting Package (constant).
CC	Carrier ID 09 FMHP (First Medical MCO) 10 MMM (MMM MCO) 12 PSM (Plan Menonita MCO) 13 SSS (Triple S MCO)
ID	Report Number (ID) assigned (Attachment 16).
YYYY	Year reported.
MM	Month reported.
DD	Day Reported (Bi-weekly reports).
R	Document version number. 0 If it is the first time you submit it. 1 If it is the second time you submit it and so on.

Example FMHP – bi-weekly report:
Report 34 – Pharmacy Certification
RP_09_34_202005200.PDF (PDF report)

Example MMM- Annual report:
Report 33 – Annual Corporate Report
RP_09_33_2020090.PDF (PDF report)

Report References and Appendices
An XSD (XML schema definition) file and XML demo are being placed in each new Citrix Share directory named "Guias_y_Plantillas_Reportes" with the folder named as the ID number and short name for each report to describe the elements required in the XML file.

Use the XSD to generate the XML file associated with each report that requires it. The other reports must use the location associated with the department and frequency as previously defined. Refer to Appendix 1 in this guide for reports that are required to be submitted in XML.

The reference values for these reports are stored in the file ases_types.xsd located in the root of the Citrix Share directory named "Guias_y_Plantillas_Reportes".

XML Files and their Attestations
Reports that have an associated file in XML format must be submitted with their corresponding attestation file, which must have the same sequence number.

The attestation file is a PDF that must have the following nomenclature RP_CC_ID_YYYYMMRATT.PDF.

Any other PDF file that must be submitted for analysis, review or additional information of the reported data, must be concatenated or added in the same PDF document attestation.

In summary, only one XML and one PDF are expected. Please refer to Appendix 1 for more details.

Reports in PDF format
A group of reports come only in PDF format, that is, they do not require XML. Refer to Appendix 1 for the associated reports. The information to be reported and its corresponding attestation must be submitted in a single file in PDF format following the nomenclature RP_CC_ID_YYYYMMRATT.PDF.

ASES Feedback and Resubmissions
ASES will provide feedback to the Contractor regarding format and timeliness of reports within forty-five (45) calendar days from the due date of the report. If a report is rejected, the Contractor must resubmit the report within 10 business days of the rejection or as otherwise may be directed by ASES.

Attestations
The Contractor must submit a signed attestation for each report in the corresponding Citrix ShareFile location with each submission or re-submission using the specified nomenclature. Failure to submit an attestation will deem the report incomplete and may result in liquidated damages in accordance with Section 20.4.1.1 of the Plan Vital contract.

Attestation nomenclature
The following nomenclature should be used to each attestation. Use the same guidelines for the XML file nomenclature:

Monthly, Quarterly, Annually	RP_CC_ID_YYYYMMRATT.PDF
Bi-Weekly	RP_CC_ID_YYYYMMDDRATT.PDF

Example: FMHP – bi-weekly report
Report 34 – Pharmacy Certification
RP_09_34_202005200ATT.PDF (Attestation)

Example: MMM- Annual report:
Report 33 – Annual Corporate Report
RP_09_33_2020090ATT.PDF (Attestation)

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Report Specifications
Report 1 – Call Center Report

Citrix Share link location:

CITRIX SHARE LOCATION
Customer Services > 2-Monthly

Purpose:

The Call Center Report captures information about Enrollee services, Provider services, and Medical Advice lines.

Submission Requirement:

The report is due on a monthly basis and monitors the requirements of 6.19 and 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
1.A through 1.C Call Center Statistics	
Calls Received	For each service line, enter the total number of calls received for the service line (e.g., all calls answered plus abandoned calls) during the reporting period.
Abandoned Calls	For each service line, enter the number of calls that were initiated to the call center but ended before being answered by a live voice or accessing a caller-selected option.
Abandoned Calls %	**Definition:** For each service line, the percentage of calls received that were abandoned. No data entry required. **Contract Standard:** = < 5% **Formula:** Abandoned calls divided by Calls Received.
Blocked Calls	For each service line, enter the number of calls that cannot connect immediately because no circuit is available at the time the call arrives.
Blocked Calls %	**Definition:** For each service line, the percentage of calls received that were blocked. No data entry required. **Contract Standard:** = < 3% **Formula:** Blocked calls divided by Calls Received.
Calls Answered	For each service line, enter the number of calls that were answered by a live voice, as opposed to being blocked, abandoned or left in voicemail.

PARAMETER	DEFINITION AND SPECIFICATION
Answered within 30 Seconds	For each service line, enter the number of calls that were answered by a live voice within 30 seconds. Time measured begins when the Enrollee is placed in the call queue to wait to speak to an Enrollee Services representative.
Answered within 30 Seconds %	**Definition:** For each service line, the percentage of calls received that were answered within 30 seconds. No data entry required. **Contract Standard:** = > 80% **Formula:** Answered within 30 Seconds divided by Calls Answered.
Average Talk Time	For each service line, enter the average amount of time from answer by live a voice to completion of the call. This is an average for the entire reporting period. (1.5 = 1 minute 30 seconds)
Average Wait Time	For each service line, enter the average amount of time callers who are placed in the queue wait before being answered by a live voice. This is an average for the entire reporting period. (1.5 = 1 minute 30 seconds)
TDD	For each service line, enter the number of calls answered that used the Telecommunication Device for the Deaf (TDD) system.
Voicemails Received	For each service line, enter the total number of messages received from enrollees and other callers during the reporting period.
Voicemails Returned	For each service line, enter the number of messages for which a return (outbound) call was made.
Returned By Next Business Day	For each service line, enter the number of messages for which a return (outbound) call was made by the next business day.
Returned By Next Business Day %	**Definition:** For each service line, the percentage of messages for which a return (outbound) call was made by the next business day. No data entry required. **Contract Standard:** = 100% **Formula:** Returned By Next Business Day divided by Voicemails Received.
Offers to Use Interpreter	For each service line, enter the total number of calls in which the agent offered to use interpreter services for the call during the reporting period, other than English or Spanish. **Rule Validations**: Optional field when section is Provider Call Center.
Acceptances	For each service line, enter the number of calls in which the caller accepted the offer of using interpreter services for the call. **Rule Validations**: Optional field when section is Provider Call Center.
Declines	For each service line, enter the number of calls in which the caller declined the offer of using interpreter services for the call. **Rule Validations**: Optional field when section is Provider Call Center.

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PARAMETER	DEFINITION AND SPECIFICATION
Warm Transfers	For the information and provider services lines, enter the number of calls that were transferred through warm transfers to another service line during the reporting period. **Rule Validations**: Optional field when section is Provider Call Center.
1.D Staffing	
GHP Service Line	Enter the total number of fulltime staff/agents for all service lines as of the last day of the reporting period.
Information Service Line Agents	Enter the number of full time staff/agents dedicated to the information service line.
Information Service Line Agents %	**Definition:** The percentage of GHP service line staff dedicated to the information service line. No data entry required. **Formula:** Information Service Line Agents divided by GHP Service Line.
Provider Call Center Agents	Enter the number of full time staff/agents dedicated to the provider call center.
Provider Call Center Agents %	**Definition:** The percentage of GHP service line staff dedicated to the provider call center line. No data entry required. **Formula:** Provider Call Center Agents divided by GHP Service Line.
Medical Advice Line Agents	Enter the number of full time staff/agents dedicated to the medical advice line.
Medical Advice Line Agents %	The percentage of GHP service line staff dedicated to the medical advice line. No data entry required. **Formula:** Medical Advice Line Agents divided by GHP Service Line.
Medical Advice Line Agents 7am-7pm	Of the number of fulltime staff/agents in the (24hr) medical advice service line, enter the number of agents dedicated to accept calls between 7:00am through 7:00pm.
Medical Advice Line Agents 7am-7pm %	**Definition:** The percentage of medical advice line agents dedicated to accept calls between 7:00am through 7:00pm. No data entry required. **Formula:** Medical Advice Line Agents 7am-7pm divided by Medical Advice Line Agents.
Medical Advice Line Agents 7:01pm-6:59am	Of the number of fulltime staff/agents in the (24hr) medical advice service line, enter the number of agents dedicated to accept calls between 7:01pm through 6:59pm.

PARAMETER	DEFINITION AND SPECIFICATION
Medical Advice Line Agents 7:01pm-6:59am %	The percentage of medical advice line agents dedicated to accept calls between 7:01pm through 6:59am. No data entry required. **Formula:** Medical Advice Line Agents 7:01pm-6:59am divided by Medical Advice Line Agents.
1.E Information Line Center Call Topics	
Calls Answered	The number of calls that were answered by a live voice, as opposed to being blocked, abandoned or left in voicemail for the specific service line.
Authorization/Prior Authorization	**Definition:** The number of calls answered regarding a request for authorization or prior authorization.
Authorization/Prior Authorization %	**Definition:** For each Authorization/Prior Authorization line, the percentage of Authorization/Prior Authorization. No data entry required. **Formula:** Authorization/Prior Authorization divided by Calls Answered.
Eligibility	**Definition:** The number of calls answered regarding a request to verify eligibility.
Eligibility %	**Definition:** For each Eligibility line, the percentage of Eligibility. No data entry required. **Formula:** Eligibility divided by Calls Answered.
ID Cards	**Definition:** The number of calls answered regarding a request for new ID card; enrollee never received ID card; or information is incorrect on the ID card.
ID Cards %	**Definition:** For each ID Cards line, the percentage of ID Cards. No data entry required. **Formula:** ID Cards divided by Calls Answered.
Information of Coverage	**Definition:** The number of calls answered regarding a request to verify benefits and services provided by the GHP.
Information of Coverage %	**Definition:** For each Information of Coverage line, the percentage of Information of Coverage. No data entry required. **Formula:** Information of Coverage divided by Calls Answered.
PMG Change	**Definition:** The number of calls answered regarding a request to change primary medical group.

PARAMETER	DEFINITION AND SPECIFICATION
PMG Change %	**Definition:** For each PMG Change line, the percentage of PMG Change. No data entry required. **Formula:** Information of PMG Change divided by Calls Answered.
Provider Change	**Definition:** The number of calls answered regarding a request to change primary care provider.
Provider Change %	**Definition:** For each Provider Change line, the percentage of Provider Change. No data entry required. **Formula:** Information of Provider Change divided by Calls Answered.
MCO Change	**Definition:** The number of calls answered regarding a request to change MCO.
MCO Change %	**Definition:** For each MCO Change line, the percentage of MCO Change. No data entry required. **Formula:** Information of MCO Change divided by Calls Answered.
Referral	**Definition:** The number of calls answered regarding a request for a referral to a provider or request information referrals within the Contractor's network.
Referral %	**Definition:** The percentage of calls answered regarding a request for a referral to a provider or request information referrals within the Contractor's network. No data entry required. **Formula:** Referral divided by Calls Answered.
Transportation	**Definition:** The number of calls answered regarding a request for transportation, questions about transportation service.
Transportation %	**Definition:** The percentage of calls answered regarding a request for transportation, questions about transportation service. No data entry required. **Formula:** Transportation divided by Calls Answered.
Other	**Definition:** The number of calls answered regarding a topic of a call other than topics lists in this section.
Other %	**Definition:**

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PARAMETER	DEFINITION AND SPECIFICATION
	The percentage of calls answered regarding a topic of a call other than topics lists in this section. No data entry required. **Formula:** Other divided by Calls Answered.
1.F Provider Line Center Call Topics	
Calls Answered	The number of calls that were answered by a live voice, as opposed to being blocked, abandoned or left in voicemail for the specific service line.
Authorization/Prior Authorization	**Definition:** The number of calls answered regarding a request for authorization or prior authorization.
Authorization/Prior Authorization %	**Definition:** The percentage of calls answered regarding a request for authorization or prior authorization. No data entry required. **Formula:** Authorization/Prior Authorization divided by Calls Answered.
Billing	**Definition:** The number of calls answered that relate to billing practices and or concerns.
Billing %	**Definition:** The percentage of calls answered that relate to billing practices and or concerns. No data entry required. **Formula:** Billing divided by Calls Answered.
Enrollee Complaints	**Definition:** The number of calls answered that relate to enrollee complaints.
Enrollee Complaints %	**Definition:** The percentage of calls answered that relate to enrollee complaints. No data entry required. **Formula:** Enrollee Complaints divided by Calls Answered.
Information of Coverage	**Definition:** The number of calls answered regarding a request to verify benefits and services provided by the GHP.
Information of Coverage %	**Definition:** The percentage of calls answered regarding a request to verify benefits and services provided by the GHP. No data entry required. **Formula:** Information of Coverage divided by Calls Answered.
Contracting Issues	**Definition:** The number of calls answered regarding a request to clarify contracting issues.
Contracting Issues %	**Definition:**

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PARAMETER	DEFINITION AND SPECIFICATION
	The percentage of calls answered regarding a request to clarify contracting issues. No data entry required. **Formula:** Contracting Issues divided by Calls Answered.
Pharmacy	**Definition:** The number of calls answered that relate to pharmacy concerns or prescription information.
Pharmacy %	**Definition:** The percentage of calls answered that relate to pharmacy concerns or prescription information. No data entry required. **Formula:** Pharmacy divided by Calls Answered.
Other	**Definition:** The number of calls answered regarding a topic of a call other than topics lists in this section.
Other %	**Definition:** The percentage of calls answered regarding a topic of a call other than topics lists in this section. No data entry required. **Formula:** Other divided by Calls Answered.
1.G Narrative	
Responses	For each item below, provide a narrative response for the month reported.
Narrative Question 1	Describe any changes to staffing for the call centers. Identify where the Contractor has increased or decreased staff to address call volumes for each service line.
Narrative Question 2	Identify the top five (5) call topics (most frequent) for enrollees who called the Medical Advice Line.
Narrative Question 3	For all call topics that were classified as other, provide a description of the top five (5) "other" call topics by each service line.
Narrative Question 4	Did the contractor meet all contract standards, including abandoned calls, calls answered within 30 seconds, blocked calls and message responses, for the reporting period? For any of the contract standards listed above that the contractor is not compliant with, please provide an explanation and what steps the contractor will take to resolve the issue(s).

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Report 2 – Enrollee Enrollment Materials Report

Citrix Share link location:

CITRIX SHARE LOCATION
Customer Service > 3-Quarterly

Purpose:

The Enrollee Enrollment Materials Report captures mailing of initial and replacement Enrollee Enrollment materials including Enrollee ID cards, Enrollee handbooks, and Provider directories.

Submission Requirement:

The report is due on a quarterly basis and monitors the requirements of 6.10 and 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
Definitions	
Enrollment Notices	As required in Section 5.2.6.3 of the contract, the Notice of Enrollment will explain that the Enrollee is entitled to receive Covered Services through the Contractor.
Enrollee Handbook	As required in Section 6.4 of the contract, the Enrollee handbook includes information on physical health, behavioral health and all other covered services offered in Plan Vital that has been approved by ASES.
Provider Directory	As required in Section 6.6 of the contract, the provider directory includes the names, provider group affiliations, locations, office hours, telephone numbers, websites, cultural and linguistic capabilities, completion of Cultural Competency training, and accommodations for people with physical disabilities of current Network Providers.
ID Card	As required in Section 6.8 of the contract, the Enrollee Identification (ID) card that has been approved by ASES.
2.A New Enrollments	
General	This section of the report captures the distribution of enrollment materials part of the enrollment process for enrollees during the reporting period.
Section 1 – Enrollment Notices	
Number of Enrollment Notices Sent	Enter the number of new enrollment notices mailed to enrollees during the reporting period. Note, this number includes enrollment notices that were generated through the auto-enrollment process and any enrollments that were processed outside of the auto-enrollment process.
Number of Enrollment Notices Sent Timely	Enter the number of new enrollment notices that were mailed to enrollees within five (5) business days of receiving the enrollment file from ASES.

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PARAMETER	DEFINITION AND SPECIFICATION
Number of Enrollment Notices NOT Timely	Enter the number of new enrollment notices that were not mailed to enrollees within five (5) business days of receiving the enrollment file from ASES.
Percent of Enrollment Notices Sent Timely	**Definition:** The percent of enrollment notices that were not mailed within five (5) business days of receiving the enrollment file from ASES. **Formula:** Number of Enrollment Notices Sent Timely divided by Number of Enrollment Notices Sent.
Section 2 – Enrollee Handbooks	
Number of Enrollee Handbooks Sent	Enter the number of enrollee handbooks mailed to enrollees with the notice of enrollment during the reporting period.
Number of Enrollee Handbooks Sent Timely	Enter the number of enrollee handbooks mailed to enrollees within five (5) calendar days of the notice of enrollment during the reporting period. **Contract Standard:** 5 Calendar Days.
Number of Enrollee Handbooks NOT Timely	Enter the number of enrollee handbooks that were NOT mailed to enrollees within five (5) calendar days of the notice of enrollment during the reporting period.
Percent of Enrollee Handbooks Sent Timely	**Definition:** The percent of enrollee handbooks mailed to enrollees within five (5) calendar days of enrollment notification. **Formula:** Number of Enrollee Handbooks Sent Timely divided by Number of Enrollee Handbooks Sent.
Section 3 – Provider Directories	
Number of Provider Directories Sent	Enter the number of provider directories mailed to enrollees within five (5) calendar days of sending the notice of enrollment during the reporting period.
Number of Provider Directories Sent Timely	Enter the number of provider directories mailed to enrollees within five (5) calendar days of sending the notice of enrollment during the reporting period. **Contract Standard:** 5 Calendar Days.
Number of Provider Directories NOT Timely	Enter the number of provider directories that were not mailed to enrollees within five (5) calendar days of notice of enrollment during the reporting period.
Percent of Provider Directories Sent Timely	**Definition:** The percent of provider directories mailed to enrollees within five (5) calendar days of enrollment notification. **Formula:** Number of Provider Directories Sent Timely divided by Number of Provider Directories Sent.

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PARAMETER	DEFINITION AND SPECIFICATION
Section 4 – Enrollee ID Cards	
Number of ID Cards Sent	Enter the number of ID Cards mailed to enrollees with the notice of enrollment during the reporting period.
Number of ID Cards Sent Timely	Enter the number of ID cards mailed to enrollees within five (5) business days of enrollment notification. **Contract Standard:** 5 Business Days.
Number of ID Cards NOT Timely	Enter the number of ID cards that were not mailed to enrollees within five (5) business days of enrollment notification.
Percent of ID Cards Sent Timely	**Definition:** The percent of ID cards mailed to enrollees within five (5) calendar days of enrollment notification. **Formula:** Number of ID Cards Sent Timely divided by Number of ID Cards Sent.
2.B Enrollee Requests	
General	This section of the report captures enrollee requests made by enrollees during the reporting period, outside of the new enrollment process.
Section 1 – Enrollee Handbooks	
Number of Enrollee Handbook Requests	Enter the number of requests received for the Enrollee Handbook during the reporting period.
Number of Enrollee Handbooks Sent Timely	Enter the number of Enrollee Handbooks sent to enrollees within five (5) business days of the request.
Number of Enrollee Handbooks Not Sent Timely	Enter the number of Enrollee Handbooks sent to enrollees in more than five (5) business days of the request. **Contract Standard:** 5 Business Days.
Percent of Enrollee Handbooks Sent Timely	**Definition:** The percent of Enrollee Handbooks sent to enrollees within five (5) business days of enrollee request. **Formula:** Number of Enrollee Handbooks Sent Timely divided by Number of Enrollee Handbooks Requests.
Section 2 – Provider Directory	
Number of Provider Directory Requests	Enter the number of requests received for the provider directory during the reporting period.
Number of Provider Directory Sent	Enter the number of provider directories sent to enrollees within five (5) business days of the request.

PARAMETER	DEFINITION AND SPECIFICATION
Percent of Provider Directory Sent	**Definition:** The percent of Provider Directories sent to enrollees within five (5) business days of enrollee request. **Formula:** Number of Provider Directories Sent divided by Number of Provider Directory Requests.
Section 3 – Enrollee ID Cards	
Number of Enrollee ID Card Requests	Enter the total number of requests received for a replacement Enrollee ID during the reporting period.
Lost, Stolen, Damaged	Enter the number of requests received for a replacement Enrollee ID during the reporting period that were due to a lost, stolen or damaged ID card. **Contract Standard:** 10 calendar days.
Name Change	Enter the number of requests received for a replacement Enrollee ID during the reporting period that was due to a name change. **Contract Standard:** 10 calendar days.
PMG/PCP Change	Enter the number of requests received for a replacement Enrollee ID during the reporting period that was due to a PMG/PCP change. **Contract Standard:** 20 calendar days.
Number of Enrollee ID Cards Sent Timely	Enter the total number of enrollee ID cards sent timely during the reporting period. Note fulfillment time frames vary based on the reason for replacement ID card. This is a sum of all enrollee ID cards sent timely.
Number of ID Cards Not Sent Timely	Enter the total number of enrollee ID cards not sent timely during the reporting period. Note fulfillment timeframes vary based on reason for replacement ID card. This is a sum of all enrollee ID cards not sent timely.
Percent of Enrollee ID Cards Sent Timely	**Definition:** The percent of Enrollee ID cards sent to enrollees timely from enrollee request. **Formula:** Number of Enrollee ID Card Sent Timely divided by Number of Enrollee ID Card Requests.
2.C Analysis	
Analysis Question 1	Describe the health plan's process for mailing initial and replacement enrollment materials (including auto-enrollment notices, enrollee handbooks, enrollee ID cards and provider directories) in a timely manner, as specified in the contract.
Analysis Question 2	Did the health plan mail all initial enrollment materials in a timely manner? If the answer is no, please explain why and what action the health plan will take to ensure enrollment materials are issued in a timely manner.
Analysis Question 3	Did the health plan mail all replacement enrollment materials in a timely manner? If the answer is no, please explain the actions the health plan will take to ensure enrollment materials are issued in a timely manner.

Report 3 – Fraud, Waste, Abuse Report

Citrix Share link location:

CITRIX SHARE LOCATION
Compliance > 3-Quarterly

Purpose:

The Fraud, Waste and Abuse (FWA) Report captures FWA activities including FWA cases, allegations, investigations, service verifications, suspensions and terminations.

Submission Requirement:

The report is due on a quarterly basis and monitors the requirements of 13 and 18.2 of the contract. Only FWA activities should be captured in this report.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
3.A FWA Cases	
Section 1 – All FWA Cases	
All FWA Cases	**Definition:** The total number of all investigative cases related to FWA which includes the sum of both Provider and Enrollee cases.
Section 2 – Provider Cases	
Provider Cases	**Definition:** Investigative cases into FWA activities that originated with an initial allegation against a provider/facility.
Section 3 – Enrollee/Other Cases	
Enrollee/Other Cases	**Definition:** Investigative cases into FWA activities that originated with an initial allegation against an enrollee or another entity that is not a provider.
Number of Cases pending at beginning of the Reporting Period (Carried Over)	**Definition:** Applies to all case types - including enrollees and providers which must be reported separately. For quarterly data, enter the number of investigative cases into FWA activities that were carried over from the previous reporting period. For monthly data, enter the number of investigative cases into FWA activities that were carried over from the previous monthly period.
Number of Cases Open during the Reporting Period	**Definition:** Applies to all case types - including enrollees and providers which must be reported separately.

PARAMETER	DEFINITION AND SPECIFICATION
	For quarterly data, enter the number of investigative cases into FWA activities that were opened during the reporting period. For monthly data, enter the number of investigative cases into FWA activities that were opened during the previous monthly period.
Number of Cases Closed during the Reporting Period	**Definition:** Applies to all case types - including enrollees and providers which must be reported separately. For quarterly data, enter the number of investigative cases into FWA activities that were closed during the reporting period. For monthly data, enter the number of investigative cases into FWA activities that were closed during the previous month period.
Number of Cases Pending at the End of the Reporting Period	**Definition:** Applies to all case types - including enrollees and providers which must be reported separately. For quarterly data, enter the number of investigative cases into FWA activities that are still open as of the last day of the reporting period. For monthly data, enter the number of investigative cases into FWA activities that are still open as of the last day of the previous month period.
Number of Cases Referred to ASES this Reporting Period	**Definition:** Applies to all case types - including enrollees and providers which must be reported separately. For quarterly data, enter the number of investigative cases into FWA activities that were referred to ASES during the reporting period. For monthly data, enter the number of investigative cases into FWA activities that were referred to ASES during the previous month period.
Number of Cases Referred to a Government Agency this Reporting Period	**Definition:** Applies to all case types - including enrollees and providers which must be reported separately. For quarterly data, enter the number of investigative cases into FWA activities that were referred to law enforcement or a government agency (i.e., MFCU, OIG, Medicaid) during the reporting period. For monthly data, enter the number of investigative cases into FWA activities that were referred to law enforcement or a government agency (i.e., MFCU, OIG, Medicaid) during the previous monthly period.
Overpayment	**Definition:** Applies to all case types - including enrollees and providers which must be reported separately. Enter the estimated identified dollar amount (total across all case types and for each type), that may have been overpaid to a person or entity identified as part of a case opened for an FWA activity. Overpayments are any funds that a person or entity receives which that person or entity is not entitled to under Title XIX of the Social Security Act as defined in 42 CFR 438.2. Overpayments shall not include funds that

PARAMETER	DEFINITION AND SPECIFICATION
	have been subject to a payment suspension or that have been identified as a Third Party Liability as set forth in Section 23.4 of the contract. **Data Format**: Refer to Data Field section associated to Dollar Amount fields
3.B Initial Allegations	
Section 1 – Provider Initial Allegations	
Total Initial Allegations for Providers	For quarterly data, enter the sum of all provider initial allegations listed below for the reporting period. For monthly data, enter the month a provider initial allegation was identified.
Altering or Falsifying Documents or Medical Records	**Definition:** An initial allegation against a provider for altering and/or falsifying documents and/or medical records.
Claims Review, Data Analysis, Audit or Re-audits Findings, Provider Profile	**Definition:** An initial allegation against a provider identified through pre and/or post claims reviews, audits and/or other utilization reviews.
Billing for Experimental/ Investigational or Non-covered Services as Covered	**Definition:** An initial allegation against a provider for billing experimental, investigational, and/or non-covered services that were submitted claims as covered services.
Billing for Services Not Rendered or Rendered by a Person Different than the Billing Provider	**Definition:** An initial allegation against a provider for billing services for another provider or different entity different than the billing provider.
Billing for Unnecessary Services, Unbelievable Services or Overutilization Pattern	**Definition:** An initial allegation against a provider for billing unnecessary services, unbelievable services, or services that were identified as overutilization patterns.
Duplicate Charges Pattern	**Definition:** An initial allegation against a provider for billing duplicate services.
Kickbacks, Solicitation, Bribe, Rebate	**Definition:** An initial allegation against a provider for receiving or providing kickbacks, solicitations, bribes, rebates or other financial rewards for rendering and/or prescribing certain services/medication.

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PARAMETER	DEFINITION AND SPECIFICATION
Coding Issues (False Coding, Up coding, Unbundling, Wrong Modifier Use)	**Definition:** An initial allegation against a provider for false coding, up coding, unbundling, use of wrong modifier.
Practicing Beyond Scope Of License	**Definition:** An initial allegation against a provider for rendering services beyond the scope of practice, license, certification to which the provider is qualified.
Split Billing/Serial Billing Pattern	**Definition:** An initial allegation against a provider for billing services through split billing and/or serial billing patterns.
Using Other Provider TIN (taxpayer identification #)	**Definition:** An initial allegation against a provider for using an alternative and/or false tax payer identification number.
Miscellaneous Not Elsewhere Specified	**Definition:** An initial allegation against a provider for other potential fraud, waste and/or abuse not specified above.
Section 2 – Enrollee Initial Allegations	
Total Initial Allegations for Enrollees	For quarterly data, enter the sum of all enrollee initial allegations listed below for the reporting period. For monthly data, enter the month an enrollee initial allegation was identified.
Forgery of Prescriptions	**Definition:** An initial allegation against an enrollee for forging and/or falsifying prescriptions.
Misuse of ID Card	**Definition:** An initial allegation against an enrollee for misusing a Plan Vital ID card.
Misuse of Service By Parent or Guardian	**Definition:** An initial allegation against parent/guardian for using an Enrollee's Plan Vital eligibility. .
Misuse of Transportation	**Definition:** An initial allegation against an enrollee for misusing transportation benefits outside of the scope of what transportation services are intended.
Overutilization of Services	**Definition:** An initial allegation against an enrollee for the over utilization of services.
Poly-Pharmacy Abuse/Illicit Drug Seeking (enrollee)	**Definition:** An initial allegation against an enrollee for drug seeking behaviors in order to acquire prescription drugs. This includes poly-pharmacy abuse and or other activities to acquire prescriptions and drugs.
Reimbursement/TPL or Coordination Issues	**Definition:** An initial allegation against an enrollee for not disclosing and/or billing other lines of insurance.

PARAMETER	DEFINITION AND SPECIFICATION
REOMBs Feedback	**Definition:** An initial allegation against an enrollee for falsifying feedback on a recipient explanation of medical benefits (REOMB).
Selling Prescribed Drugs	**Definition:** An initial allegation against an enrollee for selling prescribed drugs for a financial benefit or for another person.
Use of ID Card by Non-Enrollee/ Impersonation	**Definition:** An initial allegation against an enrollee for providing Plan Vital ID card for a non-covered enrollee and/or impersonation.
Miscellaneous Not Elsewhere Specified	**Definition:** An initial allegation against an enrollee for other potential fraud, waste and/or abuse not specified above.
3.C Provider FWA Detail	
General	**Definition:** All cases reported in the FWA section above must be reported in this section. Cases in progress in the previous quarter must be included in the current reporting quarter. Closed cases must be included in the reporting quarter corresponding to the closing date. Once the case is closed it should not be reported in the following quarters.
Provider Name	Enter the name of the provider.
Provider NPI	Enter the national provider identifier of the provider.
Provider Specialty Code	Enter the specialty of the provider. **Data Format:** Refer to Data Field section associated with the Provider Specialty Code as well as Appendix 3 of this Guide.
City	Enter the city where the provider practice is located.
Allegation Source	Enter the source of the allegation. Available choices include: TPR - Third Party Referral - The allegation was referred from an external vendor used to mine data for anomalies. TL - Tip Line - The allegation was initiated through the MCO's compliance/fraud tip line. IA - Internal Audit - The allegation was identified and referred by internal audit staff or claims audit staff. MSV - Member Service Verification - The allegation was identified from the MCO's verification of services provided. O - Other - The allegation was identified from any other source note identified above. Please describe in the Comments field.
Initial Allegation	Use 3.B Provider Allegations (Section 1 – Provider Initial Allegations) to indicate the initial allegation of the provider.

PARAMETER	DEFINITION AND SPECIFICATION
Preliminary Investigation Initiated	Enter the date the preliminary investigation was initiated. **Data Format:** Refer to Data Field section associated to Date fields.
Preliminary Notification to ASES	Enter the date ASES was notified of the preliminary investigation. **Data Format**: Refer to Data Field section associated to Date fields **Contract Standard:** Notify ASES within two (2) Business Days.
Estimated Overpayment	Enter the dollar amount of estimated overpayment. **Data Format**: Refer to Data Field section associated to Dollar Amount fields.
Date Full Investigation Notification to ASES	If applicable, the date ASES was notified of the full investigation. **Data Format:** Refer to Data Field section associated to Date fields. **Rule Validations:** Optional field. If not applicable, leave this field blank. **Contract Standard:** To ASES within two (2) Business Days of completing the investigation.
Investigation Status	Specify the status of the investigation as INPROGRESS or CLOSED.
Closing Date	If applicable, indicate the date the investigation closed. **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If the investigation status is in progress, leave this field blank. Must have a date when the case is closed.
Disposition (of closed cases)	Indicate the disposition of the closed cases (i.e., referred to ASES, cancellation of contract, corrective action plan requested, allegation not supported). Note all credible allegations must be referred to ASES.
Overpayment Amount Identified	Enter the dollar amount of any overpayment amount identified. **Data Format**: Refer to Data Field section associated to Dollar Amount fields
Overpayment Amount Recouped	Enter the dollar amount of any overpayment amount recouped. **Data Format**: Refer to Data Field section associated to Dollar Amount fields
Date Referred to ASES as a CAF	Enter the date the case was referred to ASES as a Credible Allegation of Fraud (CAF). **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If not applicable, leave this field blank.
Comments or Clarifications	Include any additional information related to the case.
3.D Enrollee FWA Detail	
General	**Definition:** All cases reported in the FWA section above must be reported in this section. Cases in progress in the previous quarter must be included in the current reporting quarter. Closed cases must be included in the reporting quarter corresponding to the closing date. Once the case is closed it should not be reported in the following quarters.

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PARAMETER	DEFINITION AND SPECIFICATION
Enrollee or Subject Name	Enter the name of the enrollee or the subject of the investigation.
MPI	Enter the Master Patient Index. Please enter data in text format. **Data Format:** Refer to Data Field section associated with MPI field. **Rule Validations:** Required. Must be a valid MPI number.
City	Enter the enrollee's or subject's city.
Initial Allegation	Use the section above to indicate the initial allegation of the enrollee or subject.
Preliminary Investigation Initiated	Enter the date the preliminary investigation was initiated. **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If not applicable, leave this field blank.
Preliminary Notification to ASES	Enter the date ASES was notified of the preliminary investigation. **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If not applicable, leave this field blank. **Contract Standard:** Within two (2) Business Days of any initiated investigation of a suspected case of Fraud, Waste, or Abuse.
Estimated Overpayment	Enter the dollar amount of estimated overpayment. **Data Format**: Refer to Data Field section associated to Dollar Amount fields
Full Investigation Notification to ASES	If applicable, the date the full investigation was notified to ASES. **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If not applicable, leave this field blank. **Contract Standard**: Within two (2) Business Days of completing the investigation.
Investigation Status	Specify the status of the investigation as INPROGRESS or CLOSED.
Closing Date	If applicable, indicate the date the investigation closed. **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If not applicable, leave this field blank.
Disposition (of closed cases)	Indicate the disposition of the closed cases (i.e., referred to ASES, cancellation of contract, corrective action plan requested, allegation not supported). Note all credible allegations must be referred to ASES.
Overpayment Amount Identified	Indicate the dollar amount of any overpayment amount identified. **Data Format**: Refer to Data Field section associated to Dollar Amount fields
Overpayment Amount Recouped	Indicate the dollar amount of any overpayment amount recouped. **Data Format**: Refer to Data Field section associated to Dollar Amount fields
Date Referred to ASES as a CAF	If applicable, enter the date the case was referred to ASES as a Credible Allegation of Fraud (CAF). **Data Format:** Refer to Data Field section associated to Date fields
Reason for closing case	Describe why the case was closed (i.e., allegation not substantiated, case referred to other agency, etc.).

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PARAMETER	DEFINITION AND SPECIFICATION
Comments or Clarifications	Include any additional information related to the case.
3.E Provider Terminations	
Provider Full Name	Enter the name of the provider. For individual providers, use last name then first name.
Provider NPI	Enter the national provider identifier of the provider. **Data Format:** Refer to Data Field section associated to NPI fields **Rule Validations:** Mandatory field.
City	Enter the city where the provider practice is located.
Provider Specialty Code	Enter the specialty of the provider. **Data Format:** Refer to the Data Field section associated with the Provider Specialty Code as well as Appendix 3 of this Guide.
Effective Date of Termination	Enter the effective date of the termination of the provider. **Data Format:** Refer to Data Field section associated to Date fields as well as Appendix 3 of this Guide.
Date of Enrollee Notification	Enter the date all enrollees were notified of the provider termination. **Data Format:** Refer to Data Field section associated to Date fields
Government Agency Notified	Indicate whether a Government Agency was notified regarding the provider termination. Enter yes or no.
Name of Government Agency	Enter the name of the Government Agency (ASES, OIG, DOJ).
Date Government Agency was Notified	If applicable, enter the date the Government Agency (ASES, OIG, and DOJ) was notified. **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If not applicable, leave this field blank.
Reason(s) for Action Taken	Indicate the reason for actions taken with the provider that warranted a termination from Plan Vital. Reason(s) include: Reason based on requirement 42 CFR 455.416 (specify in notes section). Provider terminated/sanctioned by OIG, Medicare or other Federal Agency. Other: Specify in notes section.
3.F Provider Suspensions	
Provider Full Name	Enter the name of the provider. For individual providers, use last name then first name.
Provider NPI	Enter the national provider identifier of the provider.
City	Enter the city where the provider practice is located.
Provider Specialty Code	Enter the specialty of the provider.

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PARAMETER	DEFINITION AND SPECIFICATION
	Data Format: Refer to the Data Field section associated with the Provider Specialty Code as well as Appendix 3 of this Guide.
Effective Date of Suspension	Enter the effective date of the suspension of the provider. **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If not applicable, leave this field blank.
Type of Suspension	Specify if it is a Total or Partial suspension. Total suspension means that all payments are suspended for the provider. Partial suspension means that some bills are paid and other bills payments are suspended, for example for a specific type of service.
Reason(s) for Action Taken	**Definition:** The reason for actions taken with the provider that warranted a suspension from Plan Vital. Reason(s) include: Up code/Overcharge Medicaid program for services rendered. Billing for Services not rendered or performed. Billing for medically unnecessary services. Billing for Drugs: unlicensed or unapproved Drugs. Billing for Drugs: Brand-name drugs when generic drugs are prescribed. Billing for Drugs: short-filling prescription, but charging as if the full amount of the medication was dispensed. Unbundling – Using multiple billing codes instead of a single billing code to increase the reimbursement amount. Billing for services using stolen, deceased or otherwise inappropriate provider and/or beneficiary identification number. Billing for unlicensed or excluded services. Other – Specify in Analysis and Notes.
Dollar Amount of Payment Suspension	Enter the total dollar amount of payment suspension since the beginning of the suspension date to the last day of the reporting period. **Data Format**: Refer to Data Field section associated to Dollar Amount fields
Appeal	Enter a Yes if the provider appealed the payment suspension. Enter No if the provider did not appeal the payment suspension.
Suspension Decision Lifted	Enter Yes if the payment suspension decision was lifted as a result of provider's appeal. Enter No if the payment suspension was not lifted as a result of provider's appeal.
Dollar Amount Lifted	Enter the total dollar amount associated with the payment suspension that was lifted as a result of the provider appeals. **Data Format**: Refer to Data Field section associated to Dollar Amount fields
End Date of Suspension	Enter the end date of the provider suspension. **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If not applicable, leave this field blank.
3.G Employee and Contractor Suspension and Debarment Detail	
General	This section captures a list of employees (contractor and/or sub-contractor employees) and contractor (primary and sub-contractors).

PARAMETER	DEFINITION AND SPECIFICATION
Last Name	Enter the Last name of contractor or employee.
First Name	Enter the First name of contractor or employee.
Position	For employees only (contractor or subcontractor), indicate the position of the employee. **Rule Validations:** Optional field. If not applicable, leave this field blank.
Suspension or Debarment	Indicate if the contractor or employee were suspended or debarred.
Effective Date of Suspension or Debarment	Enter the effective date of the employee/contractor suspension or debarment. **Data Format:** Refer to Data Field section associated to Date fields
End Date of Suspension	Enter the end date of the employee/contractor suspension. **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If not applicable, leave this field blank.
Government Agency Notified	Indicate whether a Government Agency was notified regarding the employee/contraction suspension/debarment. Enter yes or no.
Name of Government Agency	Enter the name of the Government Agency (ASES, OIG, DOJ).
Date Government Agency was Notified	If applicable, enter the date the Government Agency (ASES, OIG, and DOJ) was notified. **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If not applicable, leave this field blank.
Reason(s) For Action Taken	Describe the reason for actions taken with the employee/contractor that warranted a suspension or debarment from Plan Vital.
3.H Notes	
Notes	ASES requests, in no prescribed format, that the narrative notes below provide information pertinent to the reports, including explanations of any outliers within the reported data or reasons for unusual increases or decreases, as applicable to each report. The Contractor shall also include for the FWA related report, as a qualitative analysis, information regarding investigative activities, corrective actions, prevention efforts and the results of prevention efforts. Providing comprehensive notes will limit any necessary follow-up inquires with the Contractor. If necessary, please attach any additional documentation referencing the applicable reports as a means of providing further explanation.
3.I Reasons for Termination or Suspension	
Reasons	This section lists potential reasons for termination/suspensions for providers as specified under § 455.416 Termination or denial of enrollment. The Contractor

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PARAMETER	DEFINITION AND SPECIFICATION
	ensure to follow Article 10 of the Plan Vital contract regarding notifications to ASES regarding termination of provider contracts.
3.J Service Verification	
Purpose:	This section tracks the results of Member Service Verification efforts, as described in 42 CFR § 438.608(a)(5) and 13.6 of the contract. Report all samples reviewed during the quarter. **Contract Standard:** The Contractor shall employ a methodology and sampling process prior approved by ASES to verify with its Enrollees on a monthly basis whether services billed to the Contractor by Providers were actually received. The methodology and sampling process shall include criteria for identifying "high-risk" services and Provider types. A methodology and sampling process that must be employed by the Contractor on a monthly basis is the use of explanation of benefits for the sample of enrollees within forty-five (45) Calendar Days of payment of claims. Verification that services were received based on explanation of benefits may occur by mail or by phone.
Sampling Methodology	Enter a description of the sampling methodology employed by the MCO during the reporting period. • Random Sample, all providers • Stratified Random Sample, with more providers selected from higher risk groups • Targeted Sample – sample from a specific provider group or LOC • Census – all claims for a specific provider group or LOC • Other
Sampling Population	Enter the number of claims included in the sample population.
Date:	Enter the date claims were sampled.
Claims Processed Since last Verification	Enter the claim count included in the sample population. This should include all claims since the last service verification process.
Claims Selected for Service Verification	Enter the number of claims selected to verify whether services billed were actually delivered to the member.
Letters Sent or Calls Initiated	Of the number of Claims Selected for Service Verification, enter the method used for service verification.
Claims Disputed	Of the number of Claims Selected for Service Verification, enter the number of claims that members disputed receiving the billed services.
Investigations Initiated	Of the number of Claims Selected for Service Verification, enter the number of investigations (cases) opened based on the claims disputed.
Unsuccessful Verification	Of the number of Claims Selected for Service Verification, enter the number of claims included in the sample that were not verified due to unresponsive or unreachable members.

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Report 4 – Privacy and Confidentiality Report

Citrix Share link location:

CITRIX SHARE LOCATION
Compliance > 2-Monthly

Purpose:

The Privacy and Confidentiality Report captures information on any incidents that involve the loss, theft or unauthorized use or access of Enrollee PHI.

Submission Requirement

The report is due on a monthly basis and monitors the requirements of 34.4 and 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
4.A Data Breach	
Date of Breach	If applicable, enter the date of the breach. The date must be as accurate as possible. **Data Format:** Refer to Data Field section associated to Date fields
Date of Discovery	Enter the date the contractor discovered the breach. **Data Format**: Refer to Data Field section associated to Date fields
Date of Notification to ASES	Enter the date the contractor notified ASES of the breach. **Data Format**: Refer to Data Field section associated to Date fields
Description of the Breach	Enter a brief description of what happened.
Classification of Information Disclosure	Enter a classification of the information disclosure according to the following: demographic, health care or both types of information.
Type of Information	A description of the types of unsecured protected health information that were involved in the breach such as: full name, Social Security number, date of birth, home address, account number, or disability code.
Number of Enrollees Impacted	Enter the total number of enrollees impacted by the breach.
Number of Records Impacted	Enter the total number records impacted by the breach. Records are defined as the number of cases or claims which contain disclosed PHI or financial data as the case may be.
Status of Breach	Identify the current status of the breach. Enter "Open" if the breach is under investigation; enter "Close" if the breach was resolved.
Information Recovered? (Yes/No)	Indicate if the data or information that was breached has been recovered. Enter Yes or No.

PARAMETER	DEFINITION AND SPECIFICATION
Source of Disclosure	Enter the source of the disclosure of the breach.
Method of Disclosure	Enter the method of the disclosure of the breach.
Location of Disclosure	Enter the location of the disclosure of the breach (The place where the disclosure occurred).
Corrective Action? (Yes/No)	Identify if the Contractor has taken corrective action to address the breach.
Regulation Exception	Indicate if the disclosure is an exception by HIPAA regulation and explain which one of them.
OCR Reporting Date	If applicable, enter the date the incident was reported to OCR according to the regulation date established. **Data Format**: Refer to Data Field section associated to Date fields
OCR Reference Number	Enter the number assigned by OCR.
4.B Narrative	
Narrative Question 1	For each breach reported during the reporting period. Describe the guidance given to enrollees regarding steps enrollees should take to protect themselves from potential harm resulting from the breach.
Narrative Question 2	For each breach reported during the reporting period, provide a brief description of what the contractor involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches.

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Report 5 – Systems Incident and Availability Report

Citrix Share link location:

CITRIX SHARE LOCATION
Systems > 2-Monthly

Purpose:

The Systems Incident and Availability Report capture information on any Incidents that involve unauthorized access to the Contractor's systems, databases or servers. This report shall be submitted monthly, but the Contractor shall provide the report ten (10) Business Days following an Incident.

Submission Requirement:

The report is due on a monthly basis and monitors the requirements of 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
5.A System Incidents	
Date	Enter the date the incident occurred. **Data Format**: Refer to Data Field section associated to Date fields
Event (Description)	Enter a description of the event.
System	Enter the name or description of the system.
Critical (Yes/No)	Indicate yes or no, whether the system is considered critical to operations.
Impact (Description)	Enter a description of the impact of the event on the system.
Total Downtime	Enter the total downtime caused to the system by the event. **Data Format:** Refers to Data Field section associated to hours and minutes
Data Loss	Enter a description of any lost due to the event.
Resolution	Enter the remediation actions that resolved the issue.
Resolution Date	If applicable, enter the date of resolution of the incident. **Data Format**: Refer to Data Field section associated to Date fields
Corrective Action Plan	Indicate whether a corrective action plan has been put in place to avoid repetition of the incident.
5.B System Availability	
System	Enter the name or description of the system.
Critical (Yes/No)	Indicate Yes or No, whether the system is considered critical to operations.

PARAMETER	DEFINITION AND SPECIFICATION
Function	Describe the main function(s) of the system.
Total Hours Expected Availability	Enter the number of total hours of uptime required to meet contractual standards during the reporting period. **Data Format:** Refers to Data Field section associated to hours and minutes
Actual Hours Availability	Enter the number of actual hours of uptime during the reporting period. **Data Format:** Refers to Data Field section associated to hours and minutes.
Total Scheduled Downtime	Enter the number of total hours of scheduled downtime (i.e., maintenance windows) during the reporting period. **Data Format:** Refers to Data Field section associated to hours and minutes
Number of Unscheduled Outages	Enter the number of distinct unscheduled outages during the reporting period.
Notes	Provide any additional information on the availability of the system.
5.C Notes	
Notes	Provide any additional information on system tests/availability for the reporting period.

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Report 6 – Federally Qualified Health Center (FQHC 330) Report

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 3-Quarterly

Purpose:

The Federally Qualified Health Center (FQHC 330) Report captures services rendered, visits, FFS payments, and capitated payments information for PMGs.

Submission Requirement:

The report is due on a quarterly basis and monitors the requirements of 18.2 of the contract. Specifically for this report, provide the requested information for the prior quarter to allow for 90 days run out in order to capture all services rendered.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
Definition	
FQHC	A Federally Qualified Health Center is an entity that provides outpatient care under Section 330 of the Public Health Service Act (42 U.S.C. 254b) and complies with the standards and regulations established by the Federal Government and is an eligible Provider enrolled in the Medicaid Program.
Provider Specialty and Codes (FQHC)	01 – General Medicine 08 – Family Doctor 11 – Internal Medicine 16 – Obstetrics & Gynecology 37 – Pediatrician DD – Dentist CSW – Clinical Social Worker CP – Clinical Psychologist 26 – Psychiatrist
Visit	A visit is defined as one or more related encounters. Related encounters may or may not occur on the same day. For a health service to be defined as a Medicaid/CHIP visit, it must be included in the FQHC's defined scope of services as approved by Puerto Rico and billed under the FQHC's provider number. All services must be documented in the patient's medical record in order to qualify for a visit. An individual patient may have no more than one visit per day unless: • The visits occur with two different practitioners with two different specialties • There are two separate visits with two separate diagnoses Multiple visits in a single day will be treated as a single visit unless one of the two criteria above is met. Ancillary services provided without a face to face visit as defined above between a patient and physician, clinical psychologist, psychiatrist, dentist, or, clinical social worker located at the FQHC, do not constitute a visit.

PARAMETER	DEFINITION AND SPECIFICATION
	Also, face to face visits between a patient and an excluded physician, nurse practitioner, clinical psychologist, psychiatrist, dentist, or clinical social worker shall not count as visits for the purposes of wraparound payments unless they are for an emergency service per 1903(i)(2) of the Social Security Act (SSA). Visits from dual eligible patients will be included in the total number of visits provided by the FQHC. Specifically for this report, provide the requested information for the prior quarter to allow for 90 days run out in order to capture all services rendered.
6.A Data of Visits	
	The data list of the report serves Schedule 6.B. Complete the summary information identifying the PMG, Name of PMG, Fed Tax ID of PMG, the total counts of visits for the prior quarter and provide a breakout by Federal, CHIP and State populations. **Formula:** Validates the number of visits for each population against total visits for the reporting period.
CHIP	Children's Health Insurance Program ("CHIP"): Puerto Rico's Children's Health Insurance Program established pursuant to Title XXI of the Social Security Act. All CHIP eligibility categories covered in the Puerto Rico Medicaid and CHIP State Plans eligible to enroll in Plan Vital.
Federal	All Medicaid eligibility categories covered in the Puerto Rico Medicaid eligible to enroll in Plan Vital.
State	A group eligible for participation in the GHP as Other Eligible Persons, with no Federal financial participation supporting the cost of their coverage, which is comprised of low-income persons and other groups listed in Section 1.3.1.2.1 of the contract.
Other	Any other group of Other Eligible Persons may be added during the Contract Term as a result of a change in laws or regulations.
6.B Visits and Subscriber Data Support	
PMG ID #	Enter the PMG ID Number in text format.
Claim ID	Enter the claim reference number with the procedure code reported.
Subscriber Full Name	Enter the name of the enrollee.
Subscriber Contract ID	Enter the Master Patient Index in text format.
Procedure Code (CPT)	Enter the specific procedure coded noted on the claim. Must be in Current Procedural Terminology (CPT) 2018.

PARAMETER	DEFINITION AND SPECIFICATION
Procedure Long Description	Enter the description of the CPT code.
Billing Provider NPI	Enter the national provider identifier for the billing provider. **Data Format**: Refer to the Data Field section associated with NPI
Provider Specialty Code	Enter the billing provider specialty code as noted above. **Data Format**: Refer to Data Field section associated with the Provider Specialty Code as well as Appendix 3 of this Guide.
Provider Specialty	Enter the billing provider specialty.
Provider Name	Enter the name of the billing provider.
Amount of Services Provided	Enter the dollar amount billed for services rendered for the prior quarter. **Data Format**: Refer to Data Field section associated to Dollar Amount fields.
Date of Service	Enter the date of service of the procedure(s). **Data Format**: Refer to Data Field section associated to Date fields
Payment Date	Enter the date the billing provider received payment. **Data Format**: Refer to Data Field section associated to Date fields
Payment Amount	Enter the amount the billing provider received in payment.
Fed Tax ID	Employer Identification Number (EIN) /Federal Employer Identification Number (FEIN) or the Federal Tax Identification Number for the billing provider. **Data Format**: Refer to Data Field section associated to EIN and SSN fields
Provider NPI	If applicable, enter the national provider identification number. **Data Format**: Refer to Data Field section associated to NPI fields **Rule Validations:** Optional field, if the PMG/facility does not have an NPI number, leave this field blank.
Check or ACH Number	Enter the check or ACH transaction number for payment.
Check or ACH Transaction	Indicate if the payment transaction was a check or ACH.
Category of Population Plan	Indicate the enrollee plan: Federal, CHIP or State.
6.C Total Subscribed Lives for the Quarter	
	This section of the report serves as the data list for Schedule 4 (6.D) below. Complete the summary information identifying the PMG, Name of PMG, Fed Tax ID, the total number of subscribed lives for the prior quarter and provide a breakout by Federal, CHIP and State populations as defined above for Schedule 1.

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PARAMETER	DEFINITION AND SPECIFICATION
6.D PMG Population Visits Detail by Type of Plan	
General	One sheet must be completed for each group.
Year Month	Enter each month of the reporting period.
Total Population	This field will calculate based on the input for the individual population detail.
Total Population Visits	This field will calculate based on the input for the individual population detail.
CHIP	Enter the CHIP population for the group, as of the last day of each month in the report period.
CHIP – Visits	Enter the CHIP count of visits to the group, as of the last day of each month in the report period.
CHIP – % of. Population	**Definition** The percent of CHIP enrollees in the group, as of the last day of each month in the report period. **Formula:** CHIP divided by Total Population.
Federal	Enter the Federal population for the group, as of the last day of each month in the report period.
Federal – Visits	Enter the Federal count of visits to the group, as of the last day of each month in the report period.
Federal – % of Population	**Definition** The percent of Federal enrollees in the group, as of the last day of each month in the report period. **Formula:** Federal divided by Total Population.
State	Enter the State population for the group, as of the last day of each month in the report period.
State – Visits	Enter the State count of visits to the group, as of the last day of each month in the report period.
State – % of Population	**Definition** The percent of State enrollees in the group, as of the last day of each month in the report period. **Formula:** State divided by Total Population.
Others	Enter the Other population for the group, as of the last day of each month in the report period.
Others – Visits	Enter the Other count of visits to the group, as of the last day of each month in the report period.

PARAMETER	DEFINITION AND SPECIFICATION
Others – % of Population	**Definition** The percent of Other enrollees in the group, as of the last day of each month in the report period. **Formula:** Other divided by Total Population.
6.E Fee-for-Service Payments During the Quarter	
	This section of the report serves as the data list for Schedule 6 (6F). Complete the summary information identifying the PMG, Name of PMG, Fed Tax ID, the total amount of FFS payment for each month and the total FFS payments made for the prior quarter.
6.F FFS Payment Detail	
General	One sheet must be completed for each group.
PMG ID #	Enter the PMG ID Number in text format.
Subscriber Full Name	Enter the name of the enrollee.
Subscriber Contract ID	Enter the Master Patient Index in text format. **Data Format:** Refer to Data Field section associated to MPI field **Rule Validations:** Required. Must be a valid MPI number.
DOB	Enter the date of birth of the enrollee. **Data Format**: Refer to Data Field section associated to Date fields
Service Date	Enter the date of service of the procedure(s). **Data Format**: Refer to Data Field section associated to Date fields
Type of Service	Enter the type of service rendered.
Procedure/NDC Code	Enter the specific procedure coded noted on the claim. Must be in Current Procedural Terminology (CPT) 2018 or NDC.
Procedure/NDC description	Enter a description of the CPT or NDC code.
Provider Name	Enter the name of the billing provider.
Fed Tax ID	Enter, the employer Identification Number (EIN) /Federal Employer Identification Number (FEIN) or the Federal Tax Identification Number for the billing provider. **Data Format**: Refer to Data Field section associated to EIN and SSN fields **Rule Validations:** Mandatory field.
Provider NPI	Enter the national provider identifier for the billing provider. **Data Format**: Refer to Data Field section associated to NPI **Rule Validations:** Optional field. If not applicable, leave this field blank.

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PARAMETER	DEFINITION AND SPECIFICATION
Provider Specialty Code	Enter the billing provider specialty code. **Data Format**: Refer to Data Field section associated with the Provider Specialty Code as well as Appendix 3 of this Guide.
Third Party Providers: 330 Provider or Other Provider	Indicate if the provider is a "330 Provider" or "Other Provider".
Claim ID Number	The claim reference number with the procedure code reported.
Paid Amount	The dollar amount billed for services paid. **Data Format**: Refer to Data Field section associated to Dollar Amount fields.
Payment Date	The date of payment. **Data Format**: Refer to Data Field section associated to Date fields
Check Number or ACH Number	The check or ACH transaction number for payment.
Check Description	Indicate if the payment transaction was a check or ACH.
6.G Capitation PMG Payment	
	This serves as a data list for capitation PMG payments. Complete the summary information identifying the PMG, Name of PMG, Fed Tax ID, the total amount of Capitation payments for each month and the total capitation payments made for the prior quarter.
6.H FQHC Federal Tax Identification by PMG	
PMG Code	Enter the number of Enrollee assigned to the PMG.
IPA Name	Enter the legal name of the center/corporation.
Fed Tax ID	Enter the employer Identification Number (EIN) /Federal Employer Identification Number (FEIN) or the Federal Tax Identification Number. **Data Format**: Refer to Data Field section associated to EIN and SSN fields **Rule Validations:** Mandatory field.
Provider NPI	Enter the national provider identification number. If the PMG/facility does not have an NPI number, leave this field blank. **Data Format**: Refer to Data Field section associated to NPI field **Rule Validations:** Optional field. If not applicable, leave this field blank.
Physical Address	Enter the physical address of the PMG.
Town	Enter the town of the PMG.
6.I Appendix Codes and Notes	
Codes and Notes	This section serves as a reference for data required above. No data entry required in this section.

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Report 7 – Special Coverage Registry Report

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 2-Monthly

Purpose:

The Special Coverage Registry Report quantifies the number of enrollees registered for special coverage (SC) by diagnosis. This report also includes detailed parameters for enrollees registered for special coverage. The beneficiary must have been previously submitted in the eligibility file.

Submission Requirement:

The report is due on a monthly basis and monitors the requirements of 7.7 and 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
7.A Special Coverage Registry Detail	
General	The data category collects a registry of unique enrollees by condition. In the event the Enrollee has two or more conditions, the submission should reflect the primary condition. Note: Special Coverage Enrollees may qualify for HCHN (Report 8) where conditions overlap. Ensure Enrollees are listed in both places as applicable.
Municipality Code	Enter the municipality code of the enrollee. Refer to the list of municipality codes of the Carrier to ASES Data Submissions-New File Layouts-Version 4.0B. **Rule Validations:** Required.
MPI	Enter the Master Patient Index. **Data Format:** Refer to Data Field section associated with MPI field **Rule Validations:** Required. Must be a valid MPI number.
AGE	Enter the Age at the moment of the reporting period.
Gender	Enter the gender of the enrollee.
PMG ID #	Enter the PMG ID Number. **Data Format:** Refer to Data Field section associated with PMG ID field **Rule Validations:** Mandatory field.
PCP NPI	Enter the NPI of the enrollee's PCP. **Data Format**: Refer to Data Field section associated to NPI field **Rule Validations:** Mandatory field.
Type of Registry	Enter the type of registry the enrollee is in. Enter (OB) for OB-GYN. Enter SC for all others.

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PARAMETER	DEFINITION AND SPECIFICATION
SC Category	Enter the Special Coverage Category. Appendix B of the report template lists the special coverage categories.
ICD-10 Diagnostic code	Enter the specific diagnosis for granting special coverage to the enrollee. Please enter data in text format. Must be a valid ICD-10 code without any decimal points and be carried to their highest degree of detail.
Start Date	Enter the start date of special coverage. **Data Format**: Refer to Data Field section associated to Date fields
End Date	Enter the end date of special coverage. **Data Format**: Refer to Data Field section associated to Date fields
New Case	Indicate if the case is new as of the first day of this reporting period. Enter "Yes" for new, enter "No" for not new.
Case Status	Enter the current status of the case as of the last day of the reporting period. Enter Open or Closed.
Expected Date of Delivery (EDD).	(OB-GYN ONLY) Enter the expected date of delivery for enrollee in special coverage. Leave blank for HR coverage. **Data Format**: Refer to Data Field section associated to Date fields
Last Menstrual Period	(OB-GYN ONLY) Enter the date of the enrollee's last menstrual period. Leave blank for HR coverage. **Data Format**: Refer to Data Field section associated to Date fields
OB or other specialist NPI	Enter the NPI caring OB-GYN or other specialist in charge of the enrollee. For example: Nephrologist, Oncologist. Leave blank if not applicable. **Data Format**: Refer to Data Field section associated to NPI fields
Reason for closing the case	Explain the reason the enrollee was removed from special coverage. Appendix C of the report template lists the acceptable closing reasons.
7.B Summary	
General	The data category collects a summary of unique enrollees by condition. In the event the Enrollee has two or more conditions, the submission should reflect the primary condition. Note: Special Coverage Enrollees may qualify for HCHN (Report 8) where conditions overlap. Ensure Enrollees are listed in both places as applicable.
Aplastic Anemia	Identified by ICD-10 coding.
Autism	Identified by ICD-10 coding.
Cancer	Identified by ICD-10 coding.

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PARAMETER	DEFINITION AND SPECIFICATION
Children With Special Needs	Special conditions of children, including the prescribed conditions in the Special Needs Children Diagnostic Manual Codes as listed in see Attachment 13 (ASES normative letters special needs children codes) of the Contract, with the exception of psychiatric disorders and intellectual disabilities.
Chronic Renal Disease Level 3	Identified by ICD-10 coding.
Chronic Renal Disease Level 4	Identified by ICD-10 coding.
Chronic Renal Disease Level 5	Identified by ICD-10 coding.
Cystic Fibrosis	Identified by ICD-10 coding.
Hemophilia	Identified by ICD-10 coding.
Leprosy	Identified by ICD-10 coding.
Lupus	Identified by ICD-10 coding.
Multiple Sclerosis/ Amyotrophic Lateral Sclerosis	Identified by ICD-10 coding.
Rheumatoid Arthritis	Identified by ICD-10 coding.
Scleroderma	Identified by ICD-10 coding.
Tuberculosis	Identified by ICD-10 coding.
HIV/Aids	Identified by ICD-10 coding.
Obstetric (OB)	Identified by ICD-10 coding.
Phenylketonuria (PKU) - Adult	Identified by ICD-10 coding.
Pulmonary Hypertension	Identified by ICD-10 coding.
Post Transplant	Identified by ICD-10 coding.
HCV (Chronic Hepatitis C)	Identified by ICD-10 coding.
Other	Enrollees registered for special conditions that do not meet any of the listed conditions.

PARAMETER	DEFINITION AND SPECIFICATION
7.C Comments	
Comments	Enter any information needed that may affect the data. If there are no comments, the field should be filled in with “no comments”.

Report 8 – High Cost High Need (HCHN) Population

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 2-Monthly

Purpose:

The High Cost High Needs (HCHN) Population captures enrollees in HCHN Categories to identify the Rate Cell used in the monthly per member per month (PMPM) payments to the Contractor. The report shall provide information on all HCHN Enrollees that are identified by the Contractor following the procedures established in Attachment 28 of the Contract. ASES will perform a validation of the conditions identified per Enrollee utilizing the monthly claims data submitted by the Contractor to ASES.

Submission Requirement:

The report is due monthly and monitors the requirements 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

For more information regarding the process see HCHN SOP.

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PARAMETER	DEFINITION AND SPECIFICATION
8.A HCHN Population Report Layout (Reference B)	
General	Include all enrollees with changes in the HCHN information during the reporting period.
Section – Transaction Information	
Transaction Type	Enter the Transaction Type related to the enrollee HCHN condition, Valid options are: **N** = Notification **W** = Withdrawal **A** = Amendment **Notification**: This option is used to inform ASES on the following situations: (a) The enrollee has been identified as having a HCHN Category for the first time. (b) The enrollee keeps having the HCHN Category based on a Last Encounter that may extend the effective end date. **Withdrawal**: This option is used to remove a previous Notification for an Enrollee on a specific HCHN Category. **Amendment**: This option is used to change the details associated to a previous Notification with no changes in the HCHN Category and Service Date. **Data Format:** 1 character alphabetic **Rule Validations:** Required. For a Withdrawal or Amendment, the following fields should match the initial Notification: Notification Date, MPI, Service Date, HCHN Category.

PARAMETER	DEFINITION AND SPECIFICATION
Notification Date	Enter the notification date. For a Notification use the Month when this transaction is reported to ASES. For a Withdrawal or Amendment use the Month on the original Notification. **Data Format:** YYYYMM 6 digits numeric **Rule Validations:** Required
Section – Enrollee Information	
MPI	Enter the Master Patient Index (MPI) of the enrollee for which the HCHN condition has been identified. **Data Format:** Refer to Data Field section associated with MPI field **Rule Validations:** Required. Must be a valid MPI number.
Section – High Cost High Need Information	
HCHN Category	Enter the enrollee's HCHN Category: Valid options are: - Cancer - Renal - High Cardio - Diabetes - Low Cardio - Pulmonary When multiple categories have been identified for a single enrollee, send one transaction per each category. The HCHN Category with the highest priority will be the one used to assign the Rate Cell. **Data Format**: 5-11 characters alphabetic **Rule Validations:** Required. For Pharmacy Claims the HCHN Category must include conditions treated by the reported medication or drug. For other Identification Sources, the HCHN Category must match the ICD-10 according to the HCHN Reference Table.
HCHN Sub-Category	Enter the HCHN Sub-Category. **Data Format**: 5-12 characters alphabetic **Rule Validations:** Required. For Pharmacy Claims the HCHN Sub-Category must include conditions treated by the reported medication or drug. For other Identification Sources, the HCHN Sub-Category must match the ICD-10 according to the HCHN Reference Table.
Identification Source	Enter the Identification Source used to establish the HCHN Category for the enrollee. Valid options are: **P**: Pharmacy Claims **D**: Certification of Diagnosis **I**: Inpatient Admission **E**: Encounter

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PARAMETER	DEFINITION AND SPECIFICATION
	Pharmacy: Pharmacy Claim containing a medication or drug that is used in the treatment of a condition corresponding to a HCHN Category and HCHN Sub-Category. Certification of Diagnosis: PCP/Specialist Diagnosis Certification and Treatment Plan used as identification for the enrollee's condition for the reported HCHN Category and HCHN Sub-Category. The MCO must have the evidence supporting the Diagnosis Certification and Treatment Plan reported readily available for ASES audit purposes. Inpatient Admission: Information related to an Inpatient Admission that is used as identification for the enrollee's condition for the reported HCHN Category and HCHN Sub-Category. The MCO must have the evidence supporting the Inpatient Admission reported readily available for ASES audit purposes. Encounter: Encounter with a PCP/Specialist which confirms the diagnosis that determines the enrollee's condition for the reported HCHN Category and HCHN Sub-Category. **Data Format:** 1 character alphabetic **Rule Validations:** Required.
Service Date	Use the following guidance depending on the Identification Source: - Pharmacy: Prescription Date - Certification of Diagnosis: Issue Date for the *Diagnosis Certification and Treatment Plan.* - Inpatient: Inpatient Admission Date. - Encounter: Service Date for the Last Encounter. **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Required.
NPI	Enter the National Provider Identifier. Use the following guidance depending on the Diagnosis Source: • Pharmacy: Attending Provider • Certification of Diagnosis: NPI for the PCP/Specialist performing the Diagnosis Certification and Treatment Plan. • Inpatient: NPI for the Inpatient Admission Facility. • Encounter: NPI for the PCP or Specialist in the Last Encounter used to identify the HCHN condition. **Data Format:** Refer to Data Field section associated to NPI fields **Rule Validations:** Required.
ICD-10	Enter the ICD-10 code used for identifying the enrollee as presenting a HCHN condition in the reported HCHN Category and HCHN Sub-Category. **Data Format:** 3-7 characters alphanumeric **Rule Validations:** Required if the Identification Source is not Pharmacy Claims. Must be a valid ICD-10 code without any decimal points and be carried to highest degree of detail.

PARAMETER	DEFINITION AND SPECIFICATION
Claim ID	Enter the Claim ID for the transaction used to identify the HCHN Category for the enrollee. **Data Format**: alphanumeric **Rule Validations:** Required if the Identification Source is a Pharmacy Claim or Encounter. Must be a valid Claim ID present on a .CLM file. Except for Inpatient Admission, claims containing service lines for laboratory or radiology should not be included.
Service Line	Enter the Service Line Number for the transaction used to identify the HCHN Category for the enrollee. **Data Format:** alphanumeric **Rule Validations:** Required if the Identification Source is Pharmacy Claim or Encounter. Must be a valid Service Line Number present on a .CLM file for the Claim ID above. If the Identification Source is Encounter the Service Line Number being referenced must contain the ICD-10 code reported. With the exception of Inpatient Admission. Service Lines based on laboratory or radiology services should not be included.
8.B Summary	
General	Include all enrollees by HCHN Category registered at the end of the month. This is a unique count and the enrollee shall be included only in one category based on the hierarchy methodology specified in attachment 28.
8.C Notes	
Notes	ASES requests, in no prescribed format, narrative notes to provide pertinent information to the reports, including explanations of any abnormalities within the reported data or reasons for unusual increases or decreases, as applicable to each of the submitted reports. Providing comprehensive notes will limit any necessary follow-up inquiries with the Contractor. If necessary, please attach any additional documentation referencing the applicable reports as a means of providing further explanation.

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Report 9 – Disclosure of Information on Annual Business Transactions

Citrix Share link location:

CITRIX SHARE LOCATION
Compliance > 5-Annually

Purpose:

The Disclosure of Information on Annual Business Transactions Report captures required disclosures as described in Section 23.7.4 of the Contract.

Submission Requirement:

The report is due on an annual basis within 90 days after the end of the Plan Vital contract year and monitors the requirements 18.2 and 23.7.4 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
Definitions	
Definition of a Party of Interest	As defined in Section 1318(b) of the Public Health Service Act, a party in interest is: • (i) Any director, officer, partner, or employee responsible for management or administration of the Contractor; (ii) any person or legal entity that is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the Contractor; (iii) any person or legal entity that is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the Contractor; or, (iv) in the case of a Contractor organized as a nonprofit corporation, an incorporator or enrollee of such corporation under applicable Puerto Rico corporation law; • Any organization in which a person or a legal entity described above is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the Contractor; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the Contractor; • Any person directly or indirectly controlling, controlled by, or under common control with the Contractor; or • Any spouse, child, or parent of an individual described above.
Types of Transactions Which Must be Disclosed	• Any sale, exchange or lease of any property between the Contractor and a party in interest; • Any lending of money or other extension of credit between the Contractor and a party in interest; and • Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

PARAMETER	DEFINITION AND SPECIFICATION
9.A Certification of Disclosure of Information on Annual Business Transactions	
General	This serves as certification that the Contractor has disclosed all require information for transactions requiring disclosures for employees, contractors and subcontractors.
9.B Disclosure of Information on Annual Business Transactions	
General	Each transaction must be listed separately on a separate row.
Name	The name of the party in interest for each transaction.
Provider Specialty Code	Enter the provider specialty code if applicable for each transaction. Refer to Appendix 3 in this guide. **Data Format**: Refer to Data Field section associated with the Provider Specialty Code as well as Appendix 3 of this Guide. **Rule Validations:** Optional field.
NPI	Enter the national provider identification number. **Data Format**: Refer to Data Field section associated to NPI fields **Rule Validations:** Optional field. Must be a valid NPI number.
Transaction Type	Enter a brief description of the type of transaction disclosed: • Any sale, exchange or lease of any property between the Contractor and a party in interest; • Any lending of money or other extension of credit between the Contractor and a party in interest; and • Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.
Total Transaction Amounts	Enter the total number of units/transactions involved during the fiscal year for the specific transaction.
Total Accrued Dollar Amount	Enter the total accrued dollar value during the fiscal year for the specific transaction.
Justification	Enter a justification of the reasonableness of the specific transaction.
9.C Subcontractors	
General	List each subcontractor separately. This section of the report captures the ownership of any subcontractor with whom the Contractor has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the day of the request.
Subcontractor Name	Enter the name of the subcontractor.

PARAMETER	DEFINITION AND SPECIFICATION
Provider Specialty Code	Enter the national provider identification number of the subcontractor. **Data Format**: Refer to Data Field section associated to NPI fields **Rule Validations:** Optional field. Must be a valid NPI number.
NPI	Enter the national provider identification number of the subcontractor. **Data Format**: Refer to Data Field section associated to NPI fields **Rule Validations:** Mandatory field. Must be a valid NPI number.
Transaction Type	Enter a brief description of the type of transaction disclosed: • Any sale, exchange or lease of any property between the Contractor and a party in interest; • Any lending of money or other extension of credit between the Contractor and a party in interest; and Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.
Total Transaction Amounts	Enter the total number of units/transactions which involved the subcontractor during the fiscal year.
Total Accrued Dollar Amount	Enter the total accrued dollar value of transactions made with the subcontractor during the fiscal year.

Report 10 – Annual Statistical Report

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 5-Annually

Purpose:

The Annual Statistical Report captures selected parameters required under Section 2, Article VII of Law 72-1993 in the layout specified by ASES. Section 2, Article VII of Law 72-1993 requires annual statistical data be submitted in two categories. The first includes data on patient access to preventative-outpatient services, primary services, specialized services and emergency room. The data supporting access to these services is reported within report 16 and report 17. Report 10 focuses on the second category of data which includes volume and services rendered by specific category of conditions. This data includes the requirement to report on specific numbers of beneficiaries by various categories.

Submission Requirement:

The report is due on an annual basis within forty-five (45) days of the end of the Puerto Rico Government's fiscal year and monitors the requirements 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
10.A Conditions	
Conditions	This field lists specific conditions that the Contractor shall use to guide the collection of data in a grouping within each condition. The following conditions are identified: Cardiac Conditions, Hypertension, Asthma, Diabetes, Cancer, Sexually Transmitted Disease, HIV/AIDS, Mental Illness, Drug Abuse or Dependence, Nicotine Abuse or Dependence, Alcohol Abuse or Dependence, Obesity. The contractor will use ICD10 diagnostic coding within the primary, secondary or tertiary placement on a clean claim to identify enrollees within each condition. The inclusion shall contain only beneficiaries that have an active diagnosis. For example, diagnoses that are "History of" will not be included. Any enrollee with one of the diagnoses within each condition will be included. There is not a continuous membership parameter for this report.
Total Enrollees by condition (may be included in more than one category)	Enter the number of enrollees with a claim within the annual reporting period included in the condition field. One beneficiary may be included in more than one condition.
Total Services Rendered	The total of all services rendered during the reporting period. **Formula:** The sum of all services identified within the Detail of Services Rendered counts.

PARAMETER	DEFINITION AND SPECIFICATION
Detail of Services Rendered counts	Enter the number of services that best fit within the following category for each beneficiary by the Conditions identified: Physician Services, Pharmacy, Clinical Laboratories, Radiology, Other Imaging Services (excluding radiology), Hospitalizations, Other, Partial Hospitalizations and Psychologist/Other mental health professional (excluding physicians). A service may be included within more than one condition if a member is seen in that service due to more than one condition.
10.B Pregnancy	
Age brackets	Defines beneficiaries by the following age brackets: Age <15, Age 15 – 19, Age 20 – 35, Age 36 – 40 and Age >40. **Formula:** The sum of all pregnant enrollees listed by age.
Total Number of Pregnant Enrollees Identified in the reporting year	Enter the number of pregnant enrollees by age bracket. If an enrollee is pregnant and moves from age bracket to another within the annual reporting period, the Contractor shall use the older age for reporting purposes.
Total Services Rendered	The total number of services rendered to pregnant enrollees during the reporting period. Data entry not required. **Formula:** The sum of all services identified within the Detail of Services Rendered counts.
Detail of Services Rendered counts.	Enter the number of services related to pregnancy that best fit within the following category for each pregnant enrollee: Physician Services, Pharmacy, Clinical Laboratories, Radiology, Other Imaging Services (excluding radiology), Hospitalizations and Other.
Distribution by Marital Status	Enter the number of pregnant enrollees by marital status as known at the end of the reporting period: Married, Single, Widowed, Divorced and Unknown. The total number of pregnant enrollees from Total Number of Pregnant enrollees identified in the reporting year should match the total number of enrollees listed within Distribution by Civil Status.
10.C Infants & Birth	
Live Births identified in the reporting year	Enter the total number of live births that occurred during the annual reporting period.
Total Number of Infants (12 months or under) identified in the reporting year	The contractor will report the number of enrollees that are 12 months or under anytime during the annual reporting period.
Total Services Rendered	The total number of services rendered during the reporting period. **Formula:** The sum of all services identified within the Detail of Services Rendered counts.

PARAMETER	DEFINITION AND SPECIFICATION
Detail of Services Rendered counts	Enter the number of services that best fit within the following category for each infant identified: Physician Services, Pharmacy, Clinical Laboratories, Radiology, Other Imaging Services (excluding radiology), Hospitalizations and Other.
10.D Vaccines	
Vaccines by Sex and Age	Enter the number of vaccines by age group: Infants (12 month or less), Children (over 1 year to 10 years), Adolescents (over 10 years to 21 years) and Adults (over 21 years) that have been administered. The age will represent the age of the beneficiary at the time of the vaccination. The categories are separated by age and also gender of the enrollee.
Vaccines total	The total number of vaccinations for the reporting period. Date entry not required. **Formula:** The sum of all vaccines entered in the age and gender categories.
Number of Vaccines	The number of vaccinations by age category for the reporting period. Data entry not required. **Formula**: The sum of all vaccines entered in the gender categories.
Unique Count of Enrollees Vaccinated	Enter the number of enrollees vaccinated during the reporting period separated by gender of the enrollee. **Formula:** The sum of gender categories.
10.E Top Ten Conditions	
Top Ten (10) condition by utilization for the fiscal year	Enter the top ten (10) conditions identified by utilization for the annual reporting period.
Total Beneficiaries by condition (may be included in more than one category)	Enter the number of beneficiaries with a claim within the annual reporting period included in the condition field. One beneficiary may be included in more than one condition.
Total Services Rendered	The total number of services rendered during the reporting period. **Formula:** The sum of all services identified within the Detail of Services Rendered counts.
Detail of Services Rendered counts.	Enter the number of services that best fit within the following category for each beneficiary by the Conditions identified: Physician Services, Pharmacy, Clinical Laboratories, Radiology, Other Imaging Services (excluding radiology), Hospitalizations, Other, Partial Hospitalizations and Psychologist/Other mental health professional (excluding physicians). A service may be included within more than one condition if a member is seen in that service due to more than one condition.

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PARAMETER	DEFINITION AND SPECIFICATION
10.F Top 50 Drugs	
Top 50 medications by utilization for the fiscal year	Enter the name of the top 50 medications by utilization during the annual reporting period. This includes J codes.
Claims Paid	The total number of claims paid for the medication listed.
Amount Paid	The total number of dollars paid on the claims for the medications listed.

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Report 11 – Claims Activity Report

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 2-Monthly

Purpose:

The Claims Activity Report captures timeliness of claims adjudication, to identify barriers to timely payment and identify causes of claims denials and provider complaints.

Submission Requirement:

The report is due on a monthly basis and monitors the requirements of 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
Definitions	
Inpatient Claims (Physical)	All claims that were received from physical inpatient facilities.
Inpatient Claims (Behavioral)	Inpatient claims from behavioral facilities only or from any billing facility that may have physical and BH services but only report in this section as a contracted network for BH services.
Professional Claims (Physical)	All claims received for physical health services as professional claims.
Professional Claims (Behavioral)	Based on billing physician to be exclusively for BH services and any billing physician that may have physical and BH services but only report in this section as a contracted network for BH services.
Dental Claims	All dental claims.
Vision Claims	Vision claims like exams and lenses and vision related services like surgeries, procedures. Not to include ancillary services.
Ancillary Claims (All Others)	Any claim that can be classified not included in categories above.
Unclassified	Any claims that were received but cannot be classified by the due date of the report.
Clean Claims	A Claim received by the Contractor for adjudication, which can be processed without obtaining additional information from the Provider of the service or from a Third Party. It includes a Claim with errors originating in the Contractor's Claims system. It does not include a Claim from a Provider who is under investigation for Fraud, Waste, or Abuse, or a Claim under review to determine Medical Necessity.
Paid Claims	Claims adjudicated during the reporting period to a paid status.

PARAMETER	DEFINITION AND SPECIFICATION
Partially Paid Claims	Claims in a paid status with denied line items.
Denied Claims	Claims adjudicated during the reporting period to a denied status.
Percent Denied	The percent of claims adjudicated during the reporting period that were denied.
Denial Reason	The reason the claim was denied. Standard denial reasons are listed.
11.A Claims Activity	
Section 1 – Claims Received During Period	
Claims Received During Period	Using the corresponding structure of values from "ases_types.xsd" Enter the number of claims and the dollar amount of claims for the month that just ended. Enter the number of claims and dollar amounts for Beginning Inventory, New Claims and Adjustments. Beginning Inventory number of claims and dollar amount should agree to the ending balance of Unadjudicated Claims from the prior month. Claims that were listed as unclassified in the New Claims (column F and G) in the prior month should be distributed in the following month in columns D and E. The net number of claims should equal 0 and the total number of classified claims should be negative. See the example below.

	A	B	C	D	E	F	G
15		Beginning Inventory		Claims received in previous month not included previously in Unclassified		New Claims	
17	Nov-19	#	$	#	$	#	$
18	Inpatient Claims (Physical)	[illegible]	$1,992,934			[illegible]	$2,344,343
19	Inpatient Claims (Behavioral)	[illegible]	$177,785			[illegible]	$424,289
20	Professional Claims (Physical)	68436	$3,033,899			68,483	$6,629,456
21	Professional Claims (Behavioral)	2311	[illegible]			4,995	[illegible]
22	Dental Claims	285	[illegible]			6,483	[illegible]
23	Vision Claims	560	[illegible]			676	[illegible]
24	Ancillary Claims (All Others)	[illegible]	[illegible]			[illegible]	[illegible]
25	Unclassified claims					3,458	$604,800
26	November-19 Total	[illegible]	[illegible]	0	$0	[illegible]	[illegible]
27	Dec-19	#	$	#	$	#	$
28	Inpatient Claims (Physical)	[illegible]	$1,529,763.57	45	[illegible]		
29	Inpatient Claims (Behavioral)	[illegible]	[illegible]	21	[illegible]		
30	Professional Claims (Physical)	56955	$5,707,112.25	2,984	[illegible]		
31	Professional Claims (Behavioral)	3554	[illegible]	[illegible]	$14,809		
32	Dental Claims	[illegible]	[illegible]	1	$81		
33	Vision Claims	[illegible]	[illegible]	3	[illegible]		
34	Ancillary Claims (All Others)	[illegible]	[illegible]	[illegible]	$112,674		
35	Unclassified claims	[illegible]	[illegible]	[illegible]	-$604,800		
36	December-19 Total	[illegible]	[illegible]	0	$0	0	$0

Adjustments dollar amount should be positive or negative, depending on whether the adjusted claim paid amount is more or less than the originally reported paid amount.

Values for New Claims and Adjustments should reflect claims RECEIVED during the month. If a claim received during the month (new) is also adjusted during the month, do not count the adjustment in the claim count in column H, but do reflect the adjusted dollar amount in column I.

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PARAMETER	DEFINITION AND SPECIFICATION
	Enter the information for the categories of service listed in xsd as defined above. **Formula:** The "Total Received" number of claims and dollar amounts will be calculated based on the input information.
Section 2 – Claims Processed During Period	
Claims Processed During Period	Using the corresponding structure of values from "ases_types.xsd" Enter the number of claims and dollar amount of claims Paid or Denied for claims processed during the reporting period. **Formula:** The sum of paid and denied claims during the month. Note that these values should reflect claims PROCESSED during the month, regardless of the date received. Enter the information for the categories of service listed in xsd as defined above.
Section 3 – Claims Timeliness for Clean Claims Processed	
Claims Timeliness for Clean Claims Processed During Period	Using the corresponding structure of values from "ases_types.xsd" Report the time to adjudicate clean claims that were processed during the month being reported. Note: The number should report the adjudication timeliness of claims PROCESSED during the month shown, even though they may have been received in prior months. Enter the number of claims for each category of service listed in xsd as defined above. Enter in the appropriate timeliness values of 0-30 days, 31-50 days and >50 days from the date of receipt of the clean claim. **Formula:** All "%" columns will calculate based on entered information.
Section 4 – Claims Pended at the End of the Period (Unadjudicated)	
Claims Pended at the End of the Period (Unadjudicated)	Using the corresponding structure of values from "ases_types.xsd" Enter the amount of claims that remain pended at the end of the month, regardless of when the claim was received. Enter in the appropriate timeliness values of 0-30 days, 31-50 days and >50 days from the date of receipt of the claim. The total amount of claims entered in each category should equal the calculated amount in "Unadjudicated". Enter the number of claims for each category of service listed in xsd as defined above.

PARAMETER	DEFINITION AND SPECIFICATION
	Formula: "Unadjudicated" will automatically calculate based on unadjudicated claims from the prior month, plus the claims received, minus the number of claims adjudicated. All "%" columns will calculate based on entered information.
11.B Denials	
General	This section of the report captures full claims denials.
Clean Claims Denied During the Period	Using the corresponding structure of values from "ases_types.xsd" Enter the number of claims and dollar amount of clean claims paid and denied during the reporting period reported by the categories of service listed in xsd as defined above. Enter the paid amounts and the denied amounts. **Formula:** The percentage information will calculate based on entered information. Enter the number of claims and dollar amount of clean claims denied during the reporting period by denial reasons. **Formula:** The totals will calculate based on entered information. The total of denials should equal the information provided in the section of denials by reason.
11.C Claims Partially Paid	
General	This section of the report captures paid claims with selected line item denials.
Total Claims Paid	Enter the count of all claims paid (fully or partially paid). **Data Validations:** The number entered must equal "11.A – Section 2 – Claims Processed During the Reporting Period – Paid (including fully or partially paid)" for each category of service for the current reporting period.
Total Claims Partially Paid	Enter the count of paid claims that include denied line items
Amount Paid	Enter the sum total dollar amount of the line items paid of the claims
Amount Denied	Enter the sum of the billed dollar amount of the denied line items of the paid claim.
Percent Partially Paid Claims	The percent of claims adjudicated during the reporting period that were partially paid. **Formula**: The totals will calculate based on entered information.
Denial Reason	Enter a count for each corresponding reason code listed below.
Denial reason	**Definition**

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PARAMETER	DEFINITION AND SPECIFICATION
Billing Errors	Including coding, place of service, bundled, unbundled, modifier required, incorrect tax id, mutually excluded codes, missing required fields or any other similar billing issue
COB related	Coordination of benefit related issue
Copayment issue	Copayment issue
Deductible issue	Deductible issue
Duplicate related	Duplicate claims, service code, DOS or any other duplicate issue
Enrollee ineligible	Enrollee ineligible on date of service or any other eligibility issues
Inconsistency related to age, diagnosis or sex	Inconsistency, invalid, missing or incomplete error due to age, diagnosis or sex
LOI/Insufficient	Lack of information/insufficient documentation to process the claim
Level of Care	Level of care adjustment
Non covered services	Non covered services or not covered at this setting or for this service or guidelines not met or exceeded, or services not ordered
Not provided by NW/PMC	Services not provided by network/primary care providers
Preauthorization, referral or certification	Preauthorization, referral or certification invalid, incomplete, absent, exceeded or any other PA/Referral/Certification related issue
Provider/Group related	Provider or group practice related issue, services not included for this provider or contract, taxonomy or incorrect or terminated provider or any other provider related issue
Services included in the capitation	Services included in the capitation
Time limitation	Denials based on Time limitation
Wrong contractor	Claims or service submitted to Wrong Contractor/Payer
All other reasons	Other errors not elsewhere specified. Please explain on the Notes tab.
11.D Notes	
Notes	ASES requests, in no prescribed format, narrative notes to provide pertinent information to the reports, including explanations of any abnormalities within the reported data or reasons for unusual increases or decreases, as applicable to each of the submitted reports. Providing comprehensive notes will limit any necessary follow-up inquiries with the Contractor. If necessary, please attach any additional

PARAMETER	DEFINITION AND SPECIFICATION
	documentation referencing the applicable reports as a means of providing further explanation.

Report 12 – Encounter Data Submission

Citrix Share link location:

CITRIX SHARE LOCATION
N/A

Purpose:

The Contractor must submit Encounter Data in a standardized format as specified by ASES (see Section 16.3 of Contract and the 'Carrier to ASES Data Submissions -New File Layouts -Version 4.0B transmitted electronically to ASES on a monthly basis. The Contractor shall provide any information and/or Data requested in a format to be specified by ASES as required to support the validation, testing or auditing of the completeness and accuracy of Encounter Data submitted by the Contractor.

Submission Requirement:

Providers shall furnish Encounter Data to the Contractor per Section 17.3.3 of the contract and the 'Carrier to ASES Data Submissions -New File Layouts -Version 4.0B to the Contract on a monthly basis. The Data shall be submitted regardless of the payment arrangement, capitated or otherwise, agreed upon between the Contractor and the Provider.

Encounter Data for all items and services provided by Network Providers, even if the Network Provider is reimbursed on a Capitated basis, must be submitted with the paid field indicating the allowed amount, even if the amount is zero (0) dollars.

Parameters:

No prescribed format.

PARAMETER	DEFINITION AND SPECIFICATION
Definitions	
Encounter Data	• (i) All Data captured during the course of a single Encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices, and equipment associated with the Enrollee receiving services during the Encounter; • (ii) The identification of the Enrollee receiving and the Provider(s) delivering the health care services during the single Encounter; and • (iii) A unique (i.e., unduplicated) identifier for the single Encounter.
HIPAA	Encounter Data must comply with HIPAA security and privacy standards and be submitted in the format and timeframe required by the Medicaid Statistical Information System (MMIS) or format required by any successor system in accordance with 42 CFR 438.818.

Report 13 – CMS 416 EPSDT

Citrix Share link location:

XLS/XML CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 5-Annually

Purpose:

The CMS 416 EPSDT Report captures parameters and documents EPSDT screening and participation rates.

Submission Requirement:

The report is due on an annual basis (March 1st of the following year) and monitors the requirements of 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

The Contractor must use the format and parameters specified by CMS 416.

Report 14 – Executive Director and Utilization Data Report

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 3-Quarterly

Purpose:

The Executive Director and Utilization Report captures summarized data for select GHP populations and providers on utilization. The data is reported according to the following subcategories: Enrollee, Special Conditions and Child, Preventable Conditions, Dental, Hospital and Emergency Room, Outpatient/Ambulatory Services, Admissions and Re-admissions and Prior Authorizations (PA).

Submission Requirement:

The report is due on a quarterly basis and monitors the requirements of 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

The data submitted within this report is exclusive to each quarter. Updates should not be made to data submitted for a previous reporting period. The charts that are included with this report will auto populate once data is entered.

PARAMETER	DEFINITION AND SPECIFICATION
Definitions	
Enrollee	A person who is currently enrolled in the Contractor's GHP Plan, as provided in this Contract, and who, by virtue of relevant Federal and Puerto Rico laws and regulations, is an Eligible Person listed in Section 1.3.1 of the Contract.
Enrollees by Age Group	The number of enrollees enrolled in the Contractor's GHP Plan at the end of the reporting quarter. The enrollees are reported by four distinct age groups: 0-21 years, 22-39 years, 40-64 years and 65+ years, based on the enrollee's age on the last day of the reporting period.
Preventable Conditions	Preventable Conditions per 7.1.1.1.1 and 7.1.1.1.2 of the contract are defined as: All hospital acquired conditions as identified by Medicare other than deep vein thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients for inpatient hospital services; and any incorrect surgical or other invasive procedure performed on a patient; any surgical or other invasive procedure performed on the incorrect body part; or any surgical or other invasive procedure performed on the incorrect patient for inpatient and non-institutional services.

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PARAMETER	DEFINITION AND SPECIFICATION
14.A Enrollees, Special Coverage, Child	
Section 1 – Enrollees	
Total Number of GHP Enrollees	**Definition:** The total number of enrollees (unique count) participating in Plan Vital at the end of the reporting period. **Formula:** This field will auto populate with the sum from the number of enrollees entered in the fields identified by age.
Total Number of Male Enrollees	Enter the number of enrollees listed or identified as male that are enrolled in the Contractor's GHP Plan at the end of the reporting period. The sum of the enrollees listed by age should equal the sum of the enrollees listed by gender. If the sums are not equal the contract shall explain the variance within the Analysis & Notes section.
Total Number of Female Enrollees	Enter the number of enrollees listed or identifying as females that are enrolled in the Contractor's GHP Plan at the end of the reporting period. The sum of the enrollees listed by age should equal the sum of the enrollees listed by gender. If the sums are not equal the contract shall explain the variance within the Analysis & Notes section.
Section 2 – Special Coverage	
Enrollees Registered for Special Coverage	Special Coverage, as defined in 7.7 of the contract, includes benefits available to provide services for Enrollees with special health care needs caused by serious illness which are listed in Attachment 7 of the contract. Enrollees are identified and screened by the Contractor using a strategy approved by ASES; those that qualify are registered, initiating Special Coverage benefits. Certain Special Coverage conditions may also be a qualifying condition subject under the HCHN Program (e.g., cancer).
Number of Enrollees (non-duplicate) who had special coverage at the beginning of the reporting period	Enter the number of enrollees in the Contractor's GHP Plan currently registered for special coverage at the beginning of the reporting period.
Number of Enrollees (non-duplicate) newly registered for special coverage during the quarter	Enter the number of enrollees in the Contractor's GHP Plan who are newly registered for special coverage anytime during the reporting period.

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PARAMETER	DEFINITION AND SPECIFICATION
Number of Enrollees (non-duplicate) whose special coverage ended during the quarter	Enter the number of enrollees in the Contractor's GHP Plan who are deemed no longer eligible for special coverage or had special coverage end for any reason anytime during the reporting period. This excludes those that lost eligibility.
Number of Enrollees (non-duplicate) under special coverage at the end of the quarter	**Definition**: The number of enrollees with active Special Coverage at the end of the reporting period. Data entry is not required. **Formula**: The number of special coverage enrollees at beginning of period plus newly registered enrollees minus the number where Special Coverage ended.
Section 3 – Services for Children	
Number of births	Enter the number of live births delivered within the reporting quarter from enrollees in the Contractor's GHP Plan. This information is to be island-wide.
Costs associated with births	Enter the sum of all paid claims associated with the labor and delivery of a birth. This information is to be island-wide. This parameter should include all inpatient and professional services associated with the birth, but not separate outpatient follow-up visits.
Number of C-Section births	Enter the number of live births via cesarean delivery within the reporting period from enrollees in the Contractor's GHP Plan.
Number of vaginal births	Enter the number of live births via vaginal delivery within the reporting period from enrollees in the Contractor's GHP Plan.
Number of vaginal births after cesarean (VBAC)	Enter the number of live births via vaginal delivery within the reporting period from enrollees who previously had a cesarean section in the Contractor's GHP Plan. This population would be a subset captured within the number of natural births.
Total number of children vaccinated in the Quarter (Ages 0-21)	Enter the number of unique enrollees in the Contractor's GHP Plan between the ages of 0-21 that have received one or more vaccinations within the reporting period. HEDIS Technical Specifications can provide a resource for the CPT billing codes that can be used to identify immunizations given.
Total number of preventive care visits	Enter the number of unique enrollees in the Contractor's GHP Plan between the ages of 0-21 that have received one or more well-child/preventive visits within the reporting period. HEDIS Technical Specifications can provide a resource for the CPT billing codes that can be used to identify well-child/preventive visits. This parameter should include only preventive visits and includes those similar to EPSDT codes.

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PARAMETER	DEFINITION AND SPECIFICATION
Top 10 inpatient physical health diagnoses in children (ages 0-21)	List the 10 most frequent physical health primary diagnoses using ICD-10 diagnostic coding for enrollees in the Contractor's GHP Plan between the ages of 0-21 that were inpatient during the reporting period based on discharge date. This parameter includes all admissions, not unique enrollees. Inpatient care can be identified using the revenue codes listed on tab Appendix A of the Health Care Improvement Program Code Book I.
Top 10 inpatient behavioral health diagnoses in children (ages 0-21)	List the 10 most frequent behavioral health primary diagnoses using ICD-10 diagnostic coding for enrollees in the Contractor's GHP Plan between the ages of 0-21 that were inpatient during the reporting period based on discharge date. This parameter includes all admissions, not unique enrollees. Inpatient care can be identified using the revenue codes listed on tab Appendix A of the Health Care Improvement Program Code Book I.
14.B Preventable Conditions	
Provider Name	Enter the name of the institution or physician caring for the enrollee when a preventable condition occurred. If more than one provider is involved list one provider per row of the report. If more than one provider is involved, clarify this information in the 14.G.
NPI	The national provider identification number. All providers are required to have an NPI number. **Data Format**: Refer to Data Field section associated to NPI fields **Rule Validations:** Mandatory field. Must be a valid NPI number.
Preventable-Condition Reported	In text format, list the preventable condition.
Number of Claims	Enter the total number of claims that the Contractor received related to the preventable condition.
Total Amount of Money Paid	Enter the total dollar amount that the Contractor paid on the claims submitted related to the preventable condition. **Data Format**: Refer to Data Field section associated with Amount fields.
Corrective actions taken (Yes or No)	Indicate if the Contractor took corrective action when the Contractor became aware of the preventable condition. Enter "Yes" if any type of corrective action was initiated and "No" if no corrective actions occurred. For any corrective action taken, the contractor must document an explanation in 14.G.
14.C Dental, Hospital, ER	
Section 1 – Dental Services	
Total number of dental services rendered	**Definition**: The total number of dental services rendered during the reporting period. **Formula**: This field will auto populate with the sum from the number of dental services entered in the following fields: diagnostic, preventive, restorative, endodontic, oral surgery, palliative.

PARAMETER	DEFINITION AND SPECIFICATION
Total cost for dental services rendered	**Definition**: The total cost for dental services rendered during the reporting period. **Formula**: This field will auto populate with the sum from the cost of dental services entered in the following fields: diagnostic, preventive, restorative, endodontic, oral surgery, palliative.
Diagnostic	Services that are identified by the Current Dental Terminology (CDT) codes or other coding set used by the Contractor to identify diagnostic dental services.
Preventive	Services that are identified by the Current Dental Terminology (CDT) codes or other coding set used by the Contractor to identify preventive dental services.
Restorative	Services that are identified by the Current Dental Terminology (CDT) codes or other coding set used by the Contractor to identify restorative dental services.
Endodontic	Services that are identified by the Current Dental Terminology (CDT) codes or other coding set used by the Contractor to identify endodontic dental services.
Oral Surgery	Services that are identified by the Current Dental Terminology (CDT) codes or other coding set used by the Contractor to identify oral surgery dental services.
Palliative	Services that are identified by the Current Dental Terminology (CDT) codes or other coding set used by the Contractor to identify palliative dental services.
Total cost for dental services	This field will auto populate with the sum from the cost of dental services entered in the following fields: diagnostic, preventive, restorative, endodontic, oral surgery, palliative.
Section 2 – Hospital Services – Physical Health	
General	This section captures the total number of hospitalizations (by discharge) with a primary physical diagnosis during the reporting period.
Total number of hospitalizations	Enter the total number of hospitalizations that occurred during the reporting period with a primary physical health diagnosis. This parameter is by discharge and not by unique enrollee. Hospitalizations are identified by referencing Appendix A of the Health Care Improvement (HCIP) code book I.
Bed days	Based on length of stay, by the discharge date, occurring within the reporting period; enter the days calculated from the day of admission to day of discharge, and based on the number of nights spent in hospital for enrollees with a primary physical health diagnosis. This parameter includes both approved and denied days.

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PARAMETER	DEFINITION AND SPECIFICATION
Average Length Of Stay (ALOS)	**Definition:** The average length of stay (ALOS) for hospitalizations discharged during the reporting period. Data entry is not required. **Formula:** The number of bed days divided by the number of hospitalizations for primary physical health diagnosis.
Unique Patients	Enter the total number of unique enrollees that were admitted for a hospitalization during the reporting period based on the discharge date with a primary physical health diagnosis.
Costs associated with hospitalizations	Enter the sum of all paid claims associated with the cost of hospitalizations with a primary physical health diagnosis that took place during the reporting period based on the discharge date. This includes any ancillary services.
Physician inpatient services cost	Enter the sum of all paid claims associated with the cost of physician charges associated with inpatient hospitalization with a primary physical health diagnosis that took place during the reporting period based on the discharge date.
Total inpatient + total inpatient physician cost	**Definition:** The total cost of hospitalizations and physician inpatient charges for inpatient hospitalizations with a physical health diagnosis. Data entry is not required. **Formula:** The sum of costs associated with hospitalizations and the physician inpatient charges.
Average cost per hospitalization	**Definition:** The average cost per hospitalization with a physical health diagnosis. Data entry is not required. **Formula:** The sum from the cost associated with hospitalizations and the physician inpatient charges divided by the total number of hospitalizations.
Top 10 diagnoses resulting in hospitalization	List the 10 most frequent physical health primary diagnoses using ICD10 diagnostic coding for enrollees in the Contractor's GHP Plan that were inpatient during the reporting period based on discharge date. This parameter includes all admissions, not unique enrollees. Inpatient care can be identified using the revenue codes listed on tab Appendix A of the Health Care Improvement Program Code Book.
Section 3 – Emergency Room– Physical Health	
Total number of emergency room visits	Enter the total number of emergency room visits that occurred during the reporting period using POS 23: Emergency Room Hospital, with a primary physical diagnosis.
Total costs for emergency room visits	Enter the total cost from the sum of paid claims of emergency room visits that occurred during the reporting quarter with a primary physical health diagnosis.

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PARAMETER	DEFINITION AND SPECIFICATION
Average cost per ER visit	**Definition:** The average cost per emergency room visit. Data entry is not required. **Formula:** The total costs for emergency room visits divided by the total number of emergency room visits.
Top 10 diagnoses resulting in an emergency room visit	List the 10 most frequent physical health primary diagnoses using ICD10 diagnostic coding for enrollees in the Contractor's GHP Plan that incurred emergency room visits during the reporting quarter. This metric includes all ER visits, not unique enrollees.
Section 4 – Behavioral Health	
General	This section captures the total number of hospitalizations (by discharge) with a primary behavioral health diagnosis during the reporting period.
Total number of hospitalizations (MH and SUD)	Enter the total number of hospitalizations that occurred during the reporting period with a primary behavioral health diagnosis. This parameter is by discharge and not by unique enrollee. Hospitalizations are identified by referencing Appendix A of the HCIP code book I.
Bed days	Based on length of stay, by the discharge date, occurring within the reporting period; enter the days calculated from the day of admission to day of discharge, and based on the number of nights spent in hospital for enrollees with a primary behavioral health diagnosis. This parameter includes both approved and denied days.
Average Length Of Stay (ALOS)	**Definition**: The average length of stay (ALOS) for hospitalizations discharged during the reporting period. Data entry is not required. **Formula**: The number of bed days divided by the number of hospitalizations for primary behavioral health diagnosis.
Unique Patients	Enter the total number of unique enrollees that were admitted for a hospitalization during the reporting period based on the discharge date with a primary behavioral health diagnosis.
Costs associated with hospitalizations	Enter the sum of all paid claims associated with the cost of hospitalizations with a primary behavioral health diagnosis that took place during the reporting period based on the discharge date. This includes any ancillary services.
Physician inpatient services cost	Enter the sum of all paid claims associated with the cost of physician charges associated with inpatient hospitalization with a primary behavioral health diagnosis that took place during the reporting period based on the discharge date.
Total inpatient + total inpatient physician cost	**Definition:** The total cost of hospitalizations and physician inpatient charges for inpatient hospitalizations with a behavioral health diagnosis. Data entry is not required. **Formula:** The sum of costs associated with hospitalizations and the physician inpatient charges.

PARAMETER	DEFINITION AND SPECIFICATION
Average cost per hospitalization	**Definition:** The average cost per hospitalizations with a behavioral health diagnosis. Data entry is not required. **Formula:** The sum from the cost associated with hospitalizations and the physician inpatient charges divided by the total number of hospitalizations.
Top 10 diagnoses resulting in hospitalization	List the 10 most frequent behavioral health primary diagnoses using ICD10 diagnostic coding for enrollees in the Contractor's GHP Plan that were inpatient during the reporting period based on discharge date. This parameter includes all admissions, not unique enrollees. Inpatient care can be identified using the revenue codes listed on tab Appendix A of the Health Care Improvement Program Code Book.
Section 5 – Emergency Room/Stabilization Units – Behavioral Health	
Total number of emergency or stabilization unit visits	Enter the total number of emergency room visits plus stabilization unit visits that occurred during the reporting period using POS 23: Emergency Room Hospital, with a primary behavioral health diagnosis.
Total costs for emergency or stabilization unit visits	Enter the total cost from the sum of paid claims of emergency room visits plus stabilization unit visits that occurred during the reporting period with a primary behavioral health diagnosis.
Average cost per ER visit	**Definition:** The average cost per behavioral emergency/stabilization visit. Data entry is not required. **Formula:** The total costs for behavioral emergency/stabilization visits divided by the total number of emergency room visits.
Top 10 diagnoses resulting in an emergency or stabilization unit visits	List the 10 most frequent behavioral health primary diagnoses using ICD10 diagnostic coding for enrollees in the Contractor's GHP Plan that incurred emergency room visits during the reporting quarter. This parameter includes all ER visits, not unique enrollees.
14.D Outpatient and Ambulatory Services	
Section 1 – Physical Health Outpatient Services	
Total Outpatient Services	**Definition:** The total count and cost of physical health outpatient services rendered during the reporting period. Data entry is not required. **Formula:** The total sum of physical health services rendered during the reporting period from Office Visits, Imaging Services, Clinical Labs, Pathology Services, Ambulatory Surgery Facilities, Other Medical Procedures and Services and All Other Ancillary Services.

PARAMETER	DEFINITION AND SPECIFICATION
Office Visits	**Definition:** The total count and cost of physical health office visits rendered during the reporting period. Data entry is not required. **Formula:** The sum of physical health services rendered from PCP FFS, PCP Capitated Encounters and Specialists within the reporting period.
PCP Fee for Service (FFS)	Enter the total number of services rendered and the associated total costs from PCPs with whom the Contractor has a FFS payment arrangement within the reporting period.
PCP Capitated Encounters	Enter the total number of services through encounters rendered and the associated total costs from PCPs with whom the Contractor has a capitated payment arrangement within the reporting period.
Specialist	Enter the total number of services rendered and the associated total costs from all specialists within the reporting period.
Encounter Ratio	**Definition:** The encounter ratio for Plan Vital enrollees for physical health services. Data entry is not required. **Formula:** The total number of PCP capitated encounters divided by the total number of the GHP enrollees (14.A/Section 1).
Imaging Services	**Definition:** The total count of imaging services rendered for physical health during the reporting period. Data entry is not required. **Formula:** The sum of the services from Radiology, CT, MRI and Other Imaging rendered during the reporting period.
Radiology	Enter the number of radiology services and associated costs within the reporting period identified by CPT code and paid claims.
CT	Enter the number of CT services and associated costs within the reporting period identified by CPT code and paid claims.
MRI	Enter the number of MRI services and associated costs within the reporting period identified by CPT code and paid claims.
Other Imaging	Enter the number of all other imaging services and associated costs within the reporting period identified by CPT code and paid claims.
Clinical Labs	Enter the number of clinical laboratory services and associated costs within the reporting period identified by CPT code and paid claims.
Pathology Services	Enter the number of pathology services and associated costs within the reporting period identified by CPT code and paid claims.

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PARAMETER	DEFINITION AND SPECIFICATION
Ambulatory Surgery Facility	Enter the number of services and associated costs within an ambulatory surgery facility identified within the reporting period identified by CPT code and paid claims.
Other Medical Procedures and Services	Enter the number of all other medical procedures and services and associated costs within the reporting period identified by CPT code and paid claims.
All Other Ancillary Services	Enter the number of all other ancillary services and associated costs within the reporting period identified by CPT code and paid claims.
Section 2 – Behavioral Health Outpatient Services	
Total Outpatient Services (Mental Health)	**Definition:** The total count and cost of behavioral health outpatient services rendered during the reporting period. Data entry is not required. **Formula:** The total sum of behavioral health services rendered during the reporting period from Office Visits, Partial Hospitalizations, Clinical Labs and any other BH Ancillary Services.
Office Visits	**Definition:** The total count and cost of behavioral health office visits rendered during the reporting period. Data entry is not required. **Formula:** The sum of behavioral health services rendered from psychiatrist, psychologist, general MD practitioners and other behavioral health practitioners within the reporting period.
Psychiatrist	Enter the number of visits and the total associated costs for services rendered on an outpatient basis by a psychiatrist as defined within the contract within the reporting period.
Psychologist	Enter the number of visits and the total associated costs for services rendered on an outpatient basis by a psychologist as defined within the contract within the reporting period.
General MD Practitioner	Enter the number of visits and the total associated costs for behavioral health services rendered on an outpatient basis by a general MD practitioner as defined within the contract within the quarterly reporting period.
Other Behavioral Practitioners	Enter the number of visits and the total associated costs for services rendered on an outpatient basis by all other behavioral health practitioners as defined within the contract within the reporting period.
Partial Hospitalizations	Enter the number of partial hospitalization days and the total associated costs rendered within the contract within the quarterly reporting period.
Clinical Labs	Enter the number and the total associated costs of clinical labs associated with behavioral health conditions within the quarterly reporting period.

PARAMETER	DEFINITION AND SPECIFICATION
All Other BH Ancillary Services	Enter the number of visits and the total associated costs for all other BH Ancillary Services rendered on an outpatient basis within the quarterly reporting period.
Section 3 – Behavioral Ambulatory Clinics	
Clinic Name	Enter the name of the clinic where services were rendered during the reporting period in text form.
NPI	Enter the national provider identification number. All providers are required to have an NPI number. **Data Format**: Refer to Data Field section associated to NPI fields **Rule Validations:** Mandatory field. Must be valid NPI number.
Municipality Code	Enter the municipality code for the behavioral health clinic. Refer to the list of municipality codes of the Carrier to ASES Data Submissions-New File Layouts-Version 4.0B. **Rule Validations:** Required.
Behavioral Providers	Enter the number of behavioral providers rendering services at the clinic; i.e., physician, psychiatrist, psychology and other behavioral health providers during the reporting period. This count only includes providers who submitted Plan Vital claims for the reporting period.
Number of Enrollees	Enter the number of enrollees (including walk-ins) who were rendered behavioral services during the reporting period at the behavioral ambulatory clinic.
14.E Admissions and Re-Admissions	
Section 1 – Admissions and Re-Admissions	
Number of Discharges from Hospital (Physical health)	Enter the total number of discharges from physical health inpatient care during the reporting period. Inpatient care can be identified using the revenue codes listed on tab Appendix A of the Health Care Improvement Program Code Book.
Number of readmissions within 30 days from hospital (physical health to physical health)	Enter the total number of discharges from physical health inpatient care with an unplanned re-admission within thirty (30) Calendar Days of the previous discharge. This applies to an admission and subsequent re-admission for physical health admissions only.
Physical Health Hospitals Readmissions %	**Definition:** The percentage of physical health readmissions for the reporting period. **Formula:** The total number of physical health admissions divided by the number of readmissions within 30 days from the hospital for the reporting period.
Number of Discharges from psychiatric hospital	Enter the total number of discharges from inpatient care within a psychiatric hospital during the reporting period. Inpatient care can be identified using the

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PARAMETER	DEFINITION AND SPECIFICATION
	revenue codes listed on tab Appendix A of the Health Care Improvement Program Code Book.
Number of readmissions within 30 days from psychiatric hospital (Behavioral Health to Behavioral Health)	Enter the total number of discharges from inpatient care within a psychiatric hospital with an unplanned re-admission within thirty (30) Calendar Days of the previous discharge. This applies to an admission and subsequent re-admission for behavioral health admissions only.
Psychiatric Hospital Readmissions %	**Definition:** The percentage of psychiatric hospital readmissions for the reporting period. **Formula:** The total number of psychiatric hospital admissions divided by the number of readmissions within 30 days from the psychiatric hospital for the reporting period.
Section 2 – Top 3 Diagnosis Codes by Type of Facility	
Top Three Readmission Diagnosis codes by Types of Facility	Enter the top three (3) most frequent diagnoses using ICD10 diagnostic coding for enrollees readmitted during the reporting period. This parameter tracks the top three (3) diagnoses for unplanned readmissions reported in the section above..The Contractor must list physical health hospitals and psychiatric hospitals separately.
Diagnosis code	For each diagnosis listed, enter the diagnoses using ICD-0 diagnostic coding.
Diagnosis narrative	For each diagnosis listed, provide a text description associated with the ICD10 diagnoses listed.
Cases readmitted	For each diagnosis listed, enter the number of readmissions associated with each diagnosis listed.
Section 3 – Top 5 Diagnosis Codes by Type of Facility	
Top Five Readmission Facilities	For both physical health hospitals and psychiatric hospitals separately, list top five (5) facilities with the highest count of re-admissions (as defined above) for the reporting period.
14.F Prior Authorizations	
Section 1 – Prior Authorization Requests Received	
General	The Contractor may define the codes to be used for each of the categories below.
Total PA Requests Received	**Definition:** The total number of prior authorization requests received during the reporting period for surgical procedures, pharmacy, equipment (DME), images, medical tests, partial hospitalization, electroconvulsive therapy (ECT) and others. **Formula:**

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PARAMETER	DEFINITION AND SPECIFICATION
	The sum of prior authorization requests received for surgical procedures, pharmacy, equipment (DME), images, medical tests, partial hospitalization, electroconvulsive therapy (ECT) and others during the reporting period.
Surgical procedures	Enter the number of prior authorization requests received for surgical procedures during the reporting period.
Pharmacy	Enter the number of prior authorization requests received for pharmaceuticals during the reporting period.
Equipment (DME)	Enter the number of prior authorization requests received for equipment (DME) during the reporting period.
Images	Enter the number of prior authorization requests received for medical imaging during the reporting period.
Medical Tests	Enter the number of prior authorization requests received for medical testing during the reporting period.
Partial Hospitalization	Enter the number of prior authorization requests received for partial hospitalization during the reporting period.
Electroconvulsive Therapy (ECT)	Enter the number of prior authorization requests received for Electroconvulsive Therapy (ECT) during the reporting period.
Other	Enter the number of prior authorization requests received for any other services during the reporting period.
Section 2 – Prior Authorization Requests Processed	
Total PA Processed	**Definition:** The total number of prior authorizations processed during the reporting period. Data entry is not required. **Formula:** The sum of the number of prior authorizations approved in full, partially approved and denied in full during the reporting period.
Total PA Requests Approved in Full	Enter the number of prior authorization requests that the Contractor has approved in full during the reporting quarter.
Total PA Requests Partially Approved	Enter the number of prior authorization requests that the Contractor has partially approved during the reporting quarter.
Total PA Requests Denied in Full	**Definition:** The total number of prior authorization requests denied by reason during the reporting period. Data entry is not required. **Formula:** The sum of the number of prior authorizations denied by reason: clinical, lack of information, exclusion of coverage or other.

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PARAMETER	DEFINITION AND SPECIFICATION
Clinical	Enter the number of prior authorization denials rendered within the reporting period due to clinical rationale within the reporting period.
Lack of Information	Enter the number of prior authorization denials rendered within the reporting period due to lack of information within the reporting period.
Exclusion of Coverage	Enter the number of prior authorization denials rendered within the reporting period due to exclusion of coverage within the reporting period.
Other	Enter the number of prior authorization denials rendered within the reporting period due to any other reason within the reporting period. A description of the reason for the PA denial should be included in 14.G.
Denials by Type of Service	**Definition:** The total number of prior authorization requests denied by type of service during the reporting period. Data entry is not required. **Formula:** The sum of the number of prior authorizations denied by reason: clinical, lack of information, exclusion of coverage or other.
Surgical procedures	Enter the number of prior authorization requests received for surgical procedures that have been denied in full or partially.
Pharmacy	Enter the number of prior authorization requests received for pharmaceuticals that have been denied in full or partially.
Equipment (DME)	Enter the number of prior authorization requests received for equipment (DME) that have been denied in full or partially.
Images	Enter the number of prior authorization requests received for medical imaging that have been denied in full or partially.
Medical Tests	Enter the number of prior authorization requests received for medical testing that have been denied in full or partially.
Partial Hospitalization	Enter the number of prior authorization requests received for partial hospitalization that have been denied in full or partially.
Electroconvulsive Therapy (ECT)	Enter the number of prior authorization requests received for Electroconvulsive Therapy (ECT) that have been denied in full or partially.
Other	Enter the number of prior authorization requests received for any other services that have been denied in full or partially.
Total PA Pending at End of Quarter	Enter the number of PA requests received during the reporting quarter that have not been processed for all types of service.

PARAMETER	DEFINITION AND SPECIFICATION
Section 3 – High Cost Enrollees Prior Authorization Requests	
HC PA Processed	**Definition:** The total number of prior authorization requests for high cost enrollees processed during reporting period. Data entry is not required. **Formula:** The sum of the number of prior authorizations processed for high cost enrollees by condition: Cancer, ESRD, Multiple Sclerosis, Rheumatoid Arthritis, Children and Youth with Special Health Care Needs, Hemophilia, and Autism.
Cancer	Enter the number of prior authorization requests processed for enrollees identified as HC due to a Cancer diagnosis during the reporting period.
ESRD	Enter the number of prior authorization requests processed for enrollees identified as HC due to End Stage Renal Disease during the reporting period.
Multiple Sclerosis	Enter the number of prior authorization requests processed for enrollees identified as HC due to a Multiple Sclerosis diagnosis during the reporting period.
Rheumatoid Arthritis	Enter the number of prior authorization requests processed for enrollees identified as HC due to a Rheumatoid Arthritis diagnosis during the reporting period.
Children and Youth with Special Health Care Needs	Enter the number of prior authorization requests processed for enrollees identified as HC due to a Children and Youth with Special Health Care Needs diagnosis during the reporting period.
Hemophilia	Enter the number of prior authorization requests processed for enrollees identified as HC due to a Hemophilia diagnosis during the reporting period.
Autism	Enter the number of prior authorization requests processed for enrollees identified as HC due to an Autism diagnosis during the reporting period.
HC PA Denied	**Definition:** The total number of prior authorization requests denied for high cost enrollees during reporting period. Data entry is not required. **Formula:** The sum of the number of prior authorizations denied for high cost enrollees by condition: Cancer, ESRD, Multiple Sclerosis, Rheumatoid Arthritis, Children and Youth with Special Health Care Needs, Hemophilia, and Autism.
Cancer	Enter the number of prior authorization requests received that have been denied in full or partially for enrollees identified as HC due to a Cancer diagnosis.
ESRD	Enter the number of prior authorization requests received that have been denied in full or partially for enrollees identified as HC due to an ESRD diagnosis.
Multiple Sclerosis	Enter the number of prior authorization requests received that have been denied in full or partially for enrollees identified as HC due to a Multiple Sclerosis diagnosis.

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PARAMETER	DEFINITION AND SPECIFICATION
Rheumatoid Arthritis	Enter the number of prior authorization requests received that have been denied in full or partially for enrollees identified as HC due to a Rheumatoid Arthritis diagnosis.
Children and Youth with Special Health Care Needs	Enter the number of prior authorization requests received that have been denied in full or partially for enrollees identified as HC due to a Children and Youth with Special Health Care Needs diagnosis.
Hemophilia	Enter the number of prior authorization requests received that have been denied in full or partially for enrollees identified as HC due to a Hemophilia diagnosis.
Autism	Enter the number of prior authorization requests received that have been denied in full or partially for enrollees identified as HC due to an Autism diagnosis.
Cancer	Enter the number of prior authorization requests received that have been denied in full or partially for enrollees identified as HC due to a Cancer diagnosis.
ESRD	Enter the number of prior authorization requests received that have been denied in full or partially for enrollees identified as HC due to an ESRD diagnosis.
Multiple Sclerosis	Enter the number of prior authorization requests received that have been denied in full or partially for enrollees identified as HC due to a Multiple Sclerosis diagnosis.
14.G Notes	
Notes	Provide pertinent information, including explanation of any abnormalities within the reported data or reasons for unusual increases or decreases, as applicable to the report. Providing comprehensive notes will limit any necessary follow-up inquiries with the Contractor. If necessary, please attach any additional documentation referencing the applicable reports as a means of providing further explanation.

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Report 15 – Network Provider List (NPL)

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 2-Monthly

Purpose:

The Network Provider List (NPL) Report captures information on the number of Network Providers in the Contractor's General and PPN network.

Submission Requirement:

The report is due on a monthly basis and monitors the requirements of 9.1 and 18.2 of the contract.

Each provider should only be listed once per specialty code in which they serve. In those instances in which the same provider renders services under multiple specialty codes, that provider must be entered as many specialty codes it is contracted for. For example, if a provider identified as a hospital and also provides outpatient services as an x-rays facility or a clinical laboratory, that provider must be entered more than once but with a different specialty code each time.

The Contractor must ensure that the listed provider open hours do not coincide across multiple office locations/municipalities for the same provider. For example, a provider should not list their office hours as 8 am - 3 pm in municipality A and 9 am - 2 pm in municipality B. The provider should list his or her hours for when the provider is actually in the office. For example, an appropriate response would be 8 am - 12 pm in municipality A and 1 pm - 4 pm in municipality B.

The Contractor shall ensure that each provider associated with a PMG is identified separately within the 15.A Master List section per PMG that provider is associated with.

The Contractor must list all special PMGs (i.e., HIV clinics with assigned lives and Renal Clinics with assigned lives) in both the 15.B PMG section as well as the 15.A Master List section if the facility has assigned lives.

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Related Contract and Legal Requirements:

1. Reporting – Article 18
2. Enforcement – Liquidated Damages and Other Remedies – Article 20
3. Law 101 of June 26, 1965, as amended, known as "Law of Facilities of Puerto Rico."

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
15.A Master List	
Municipality Code	Enter the municipality code for the provider location. Refer to the list of municipality codes of the Carrier to ASES Data Submissions-New File Layouts-Version 4.0B. **Rule Validations:** Required.

PARAMETER	DEFINITION AND SPECIFICATION
Last Name 1	Enter the last name of the provider. If the provider has two last names, this should be the first name. If the provider is a facility, enter the name of the facility.
Last Name 2	If applicable, enter the last name of the provider. If the provider has two last names, this should be the second name. **Rule Validations:** Optional field. If not applicable, leave this field blank.
First Name	If applicable, enter the first name of the provider. **Rule Validations:** Optional field. If not applicable, leave this field blank.
Physical Address 1	Enter the first line of the primary physical address of the provider.
Physical Address 2	Enter the second line of the primary physical address of the provider.
City	Enter the city of the provider. Refer to the list of municipality codes of the Carrier to ASES Data Submissions-New File Layouts-Version 4.0B.
Zip Code	Enter the zip code of the provider.
Provider Specialty Code	Enter the specialty code of the provider. **Data Format**: Refer to Data Field section associated with the Provider Specialty Code as well as Appendix 3 of this Guide.
Primary Care Physician	Identify if the provider is serving as a PCP. Enter "Yes" for if the provider is serving as PCP and "No" if he/she is not. **Data Format**: Refer to Data Field section associated with "Yes / No" fields.
PMG Identifier	Enter the identification number of the primary medical group. **Rule Validations:** Optional field. If not applicable, leave this field blank.
PMG Name	Enter the name or title of the primary medical group. Is required when PMG Identifier exists.
Co-Location or Reverse Co-Location	Indicate if the provider complies with the co-location or reverse co-location rule as defined by Contract. **Rule Validations:** Required. Identify with a "C" for co-location, a "RC" for reverse co-location and for all others "NA".
PPN	Indicate if the provider is a part of the Contractor's PPN. **Rule Validations:** If the provider is part of the contractor's PPN enter "Yes". If the Provider is not a part of the Contractor's PPN enter "No".
NPI	Enter the National Provider Identification (NPI) number for the provider. All providers are required to have an NPI number. **Data Format:** Refer to Data Field section associated to NPI fields **Rule Validations:** Mandatory field. Must be a valid NPI number. If the provider does not have an NPI, leave this field blank.
Provider ID	If applicable, enter the Provider ID as assigned by the carrier.

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PARAMETER	DEFINITION AND SPECIFICATION
	Rule Validations: Optional field, if the provider does not have a provider ID leave this field blank.
Federal Tax ID (EIN)	The federal Employer Identification Number (EIN) or Social Security Number (SSN). Enter EIN for entities/facilities, enter the SSN for individuals. **Data Format**: Refer to Data Field section associated to EIN and SSN fields **Rule Validations:** Mandatory field.
Institution Number	Enter the Institution Number of the hospital. **Data Format:** Institution number **Rule Validations:** Optional field. If the hospital does not have an Institution Number, leave this field blank. For all other types of providers, leave this field blank.
Assigned Lives	Enter the count of assigned lives to the provider per PMG as of the last day of the report period. **Rule Validations:** Only Providers that are PCP or Specialty code = 16 (Specialty Type = Obstetrics / Gynecology) or Specialty code = 39 (Specialty Type = Nephrology) must have assigned lives, otherwise the report will be rejected.
Contract Effective Date	The most recent date the provider was contracted with the Contractor. This should be the beginning date of the current contract. The provider must be contracted using an approved contract for Plan Vital. Alternative arrangements such as Letter of Intent are not acceptable. **Data Format**: Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If the provider is not contracted leave blank.
Credential Status	Identify the credentialing status of the provider as of the last day of the report period. **Data Format**: Refer to Data Field section associated with "Yes / No / NA" fields. **Rule Validations:** Mandatory field. Enter "Yes" for a fully credentialed/re-credentialed (up to date with all credentialing requirements) provider; enter **"No"** if the provider requires credentialing/re-credentialing or if any step in the credentialing process is pending. If the provider is not required to submit credentialing/credentialing: "NA".
Credential Effective Date	Enter the most recent credentialing/re-credentialing date of the provider. **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If the provider does not require credentialing, leave field blank.
Re-Credential Date	Enter the date the current provider credentialing status expires. **Data Format:** Refer to Data Field section associated to Date fields **Rule Validations:** Optional field. If the provider does not require credentialing, leave this field blank.
SAMSHA/ Buprenorphine	Identify if the provider has current SAMSHA (Substance Abuse and Mental Health Services Administration)/Buprenorphine certification. **Data Format**: Refer to Data Field section associated with "Yes / No / NA" fields. **Rule Validations:** Mandatory field. Enter "Yes" if the provider has a current certification and "No" if he/she does not. If not applicable, "NA".
Phone Number	Enter the primary phone number of the provider.

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PARAMETER	DEFINITION AND SPECIFICATION
Fax Number	Enter the primary fax number of the provider.
Sunday Office Hours	The Sunday open office hours of the provider in 12hr format, (i.e., 08:00am-05:00pm).
Monday Office Hours	The Monday open office hours of the provider in 12hr format, (i.e., 08:00am-05:00pm).
Tuesday Office Hours	The Tuesday open office hours of the provider in 12hr format, (i.e., 08:00am-05:00pm).
Wednesday Office Hours	The Wednesday open office hours of the provider in 12hr format, (i.e., 08:00am-05:00pm).
Thursday Office Hours	The Thursday open office hours of the provider in 12hr format, (i.e., 08:00am-05:00pm).
Friday Office Hours	The Friday open office hours of the provider in 12hr format, (i.e., 08:00am-05:00pm).
Saturday Office Hours	The Saturday open office hours of the provider in 12hr format, (i.e., 08:00am-05:00pm).
15.B PRIMARY MEDICAL GROUPS	
General	Indicate PMGs that operate as specialized providers with assigned lives. (i.e., HIV Clinics with assigned lives or Renal Clinics with assigned lives (category 4 and category 5 enrollees).
City	Enter the city of the PMG.
Zip Code	Enter the zip code of the PMG.
PMG Identifier	Enter the identification number of the PMG.
PMG Name	Enter the name or title of the PMG.
NPI	Enter the national provider identification number. **Data Format**: Refer to Data Field section associated to NPI fields **Rule Validations:** Optional field. If the PMG does not have an NPI number, leave this field blank.
Federal Tax ID	Enter the federal identification number of the PMG. **Data Format**: Refer to Data Field section associated to EIN and SSN fields **Rule Validations:** Optional field. If the PMG does not have a federal identification number, leave this field blank.
Assigned Lives	Enter the total number of assigned lives to the PMG as of the last day of the report period. This number should include the sum of all office locations of providers in the PMG. **Rule Validations:** If the PMG does not have or require assigned lives, enter "0". The calculation for gynecologist ratio includes females only. The minimum age of female population considered in the Gynecologist ratio is 10 years of age as defined in Adolescent Health for Healthy People 2020.

PARAMETER	DEFINITION AND SPECIFICATION
PPN	Indicate if the PMG is a part of the Contractor's PPN. **Rule Validations:** If the PMG is part of the contractor's PPN enter "Yes". If the PMG is not a part of the contractor's PPN enter "No".
Primary Office	Indicate if the entry of the PMG is for the primary office location of the PMG. A PMG may be entered multiple times if the PMG has more than one office location providing services. Enter a "0" for the first entry of the PMG in the list. Enter an "X" for any duplicate entries of the same PMG in the list.
PCP	Enter the number of PCPs (including General Practitioners, Internists, Family Doctors, Pediatricians, and Gynecologists-Obstetricians) in the PMG as of the last day of the report period. (Only include gynecologists who serve as primary care physicians.)
Gynecologist	Enter the number of gynecologists in the PMG as of the last day of the report period. Only include gynecologists that are not PCPs. The calculation for gynecologist ratio includes females only. The minimum age of female population considered in the Gynecologist ratio is 10 years of age as defined in Adolescent Health for Healthy People 2020.
Cardiologist	Enter the number of cardiologists in the PMG as of the last day of the report period.
Gastroenterologist	Enter the number of gastroenterologists in the PMG as of the last day of the report period.
Pneumologist	Enter the number of pneumologists in the PMG as of the last day of the report period.
Endocrinologist	Enter the number of endocrinologists in the PMG as of the last day of the report period.
Urologist	Enter the number of urologists in the PMG as of the last day of the report period.
Other Provider Types	Enter the total number of all other provider types in the PMG as of the last day of the report period. Only include provider types that are not PCPs. This should include physical health and behavioral health providers.
Physical Address 1	Enter the first line of the physical address of the PMG.
Physical Address 2	Enter the second line of the physical address of the PMG.
Phone Number	Enter the primary phone number of the PMG.
Fax Number	Enter the primary fax number of the PMG.

PARAMETER	DEFINITION AND SPECIFICATION
15.C Notes	
Notes	ASES requests, in no prescribed format, narrative notes to provide pertinent information to the reports, including explanations of any abnormalities within the reported data or reasons for unusual increases or decreases, as applicable to each of the submitted reports. Providing comprehensive notes will limit any necessary follow-up inquiries with the Contractor. If necessary, please attach any additional documentation referencing the applicable reports as a means of providing further explanation.

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Report 16 – Geographic Access Report

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 3-Quarterly

Purpose:

The Geographic Access Report captures geographical access information to monitor the requirements of 9.4 of the contract.

Submission Requirement:

The report is due on a quarterly basis and monitors the requirements of 18.2 of the contract. With each quarterly submission, the Contractor must submit supporting geographic access maps and data tables associated with the current period demonstrating compliance with Time and Distance requirements.

The submission of the attestation, geographic access maps and data tables must be submitted in one combined file according to ASES specifications in PDF and XML format.

Required sequence for the submission of concatenated PDF:
1. Attestation signed - It must be the first page
2. GEO Access maps
3. Data tables

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
Definitions	
PCP	The following specialties are considered PCPs: Family Practice, Internal Medicine (for Adults), General Medicine, and Pediatrics.
High Volume Specialty Care Provider	High Volume Specialty Care Providers are Providers that comprise one (1) percent of utilization for the enrolled population, as identified by ASES.
16.A Ratio Requirements	
General	This section of the report monitors compliance with Section 9.4.3.1 and 9.4.3.2 of the contract.
PCP – Adult	**Contract Standard:** The Contractor's provider network must have one (1) PCP per one thousand seven hundred (1,700) Enrollees (excluding Gynecologists).
PCP – Child	**Contract Standard:** The Contractor's provider network must have one (1) PCP per one thousand seven hundred (1,700) Enrollees (excluding Gynecologists).

PARAMETER	DEFINITION AND SPECIFICATION
Gynecologists	**Contract Standard:** The Contractor's provider network must have one (1) Gynecologist (selected as the Enrollee's PCP, if the Enrollee is female and twelve (12) years of age or older) per two thousand eight hundred (2,800) Enrollees.
Hospitals	**Contract Standard:** The Contractor's provider network must have one (1) Hospital per fifty thousand (50,000) Enrollees.
Total Provider Count	For each standard, enter the total count of providers, in the Contractor's provider network as of the last day of the reporting period.
Total Membership Count	For each standard, enter the total count of enrollees, in the Contractor's network as of the last day of the reporting period.
Met or Not Met	For each standard, indicate if the standard is met or not met as of the last day of the reporting period.
Reasons for Not Met	For each standard not met, describe the reason(s) the standard is not met. **Rule Validations:** Mandatory field. If the standard is met, leave this field blank.
16.B Municipality Requirements	
General	This section of the report monitors compliance with Section 9.4.3.3 of the contract.
PCP – Adult	**Contract Standard:** The Contractor's provider network must have two (2) Adult PCPs, as defined in Sections 9.4.4.1.1, in each municipality.
PCP – Child	**Contract Standard:** The Contractor's provider network must have one (1) Pediatric PCPs, as defined in Sections 9.4.4.2.1, in each municipality.
Psychologist	**Contract Standard:** The Contractor's provider network must have one (1) Psychologist in each municipality.
Met or Not Met	For each standard, indicate if the standard is met or not met as of the last day of the reporting period.
Reasons for Not Met	For each standard not met, describe the reason(s) the standard is not met. **Rule Validations:** Mandatory field. If the standard is met, leave this field blank.
List Municipality	For any standard that is not met, list all municipalities where the standard is not met. Refer to the list of municipality codes of the Carrier to ASES Data Submissions-New File Layouts-Version 4.0B.
16.C Facility Requirements	
General	This section of the report monitors compliance with Section 9.4.3.4 of the contract.

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PARAMETER	DEFINITION AND SPECIFICATION
Certified Buprenorphine Providers	**Contract Standard:** The Contractor's provider network must include all available certified Buprenorphine providers.
Emergency Stabilization Units	**Contract Standard:** The Contractor's provider network must include all available emergency stabilization units.
FQHC	**Contract Standard:** The Contractor's provider network must have one (1) FQHC.
Government Health Care Facilities	**Contract Standard:** The Contractor's provider network must include all Government Health Care Facilities identified in Section 9.6 of the contract.
Psychiatric Hospitals	**Contract Standard:** The Contractor's provider network must include all available psychiatric hospitals.
Psychiatric Stabilization Units	**Contract Standard:** The Contractor's provider network must include all available psychiatric partial hospitals.
Met or Not Met	For each standard, indicate if the standard is met or not met as of the last day of the reporting period.
Number of Contracted Facilities	For each standard, indicate the number of providers/facilities contracted by the Contractor as a Plan Vital provider (with an approved agreement), as of the last day of the reporting period.
Number of Available Facilities	For each standard, indicate the number of available providers/facilities identified by the Contractor island-wide, as of the last day of the reporting period.
16.D Time and Distance Requirements	
General	This section of the report monitors compliance with Section 9.4.4 of the contract. For any standard that is not met ensure the municipality is noted in 16.E.
PCP – Adult	**Contract Standard:** Providers classified as Adult PCPs for purposes of Time and Distance Standards are Internal Medicine, Family Practice, and General Practice. Enrollees living in Urban Areas and Non-Urban Areas must have a choice of at least two (2) PCPs within fifteen (15) miles/thirty (30) minutes.
PCP – Child	**Contract Standard:** Providers classified as Pediatric PCPs for purposes of Time and Distance Standards are the following: Family Practice, General Practice, and Pediatrics. Enrollees living in Urban Areas and Non-Urban Areas must have a choice of at least two (2) PCPs within fifteen (15) miles/thirty (30) minutes.

PARAMETER	DEFINITION AND SPECIFICATION
PCP – OB/GYN	**Contract Standard:** For female Enrollees age twelve (12) and older, the Contractor must ensure the provider network for OB/GYN Providers meet the following Time and Distance standards: Enrollees living in Urban Areas and Non-Urban Areas must have a choice of at least two (2) OB/GYN Providers within fifteen (15) miles/thirty (30) minutes.
Hospitals	**Contract Standard:** The Contractor must ensure Enrollees have access to all necessary specialty hospitals as needed based on the needs of the enrolled population. Enrollees living in Urban Areas must have one (1) Hospital within thirty (30) miles/sixty (60) minutes. Enrollees living in Non-Urban Areas must have one (1) Hospital within forty-five (45) miles/ninety (90) minutes.
Emergency Room (Hospital and Freestanding)	**Contract Standard:** Facilities subject to the Time and Distance standard in this section are emergency rooms, either in a Hospital or a freestanding facility. Enrollees living in any area of Puerto Rico must have one (1) Emergency Room within twenty (20) miles/thirty (30) minutes.
Adult and Pediatric Mental Health Providers	**Contract Standard:** Providers classified as Adult and Pediatric Mental Health Providers for purposes of Time and Distance standards are the following: Psychiatrists, Psychologists, Licensed Clinical Social Worker, and Licensed Marriage Counselor. Enrollees living in Urban Areas and Non-Urban Areas must have one (1) Psychologist within fifteen (15) miles/thirty (30) minutes. Enrollees living in Urban Areas and Non-Urban Areas must have one (1) Psychiatrist within fifteen (15) miles/thirty (30) minutes. Enrollees living in Urban Areas and Non-Urban Areas must have one (1) Social Worker or Licensed Marriage Counselor within fifteen (15) miles/thirty (30) minutes.
Adult and Pediatric Substance Use Disorder (SUD) Providers	**Contract Standard:** Providers classified as Adult and Pediatric SUD Providers for purposes of Time and Distance standards are the following: Addiction Medicine, Inpatient Facility, SUD Treatment Programs (including intensive outpatient, inpatient, partial hospitalization, residential and withdrawal management). Enrollees living in Urban Areas must have one (1) SUD Provider within thirty (30) miles/sixty (60) minutes. Enrollees living in Non-Urban Areas must have one (1) SUD Provider within forty-five (45) miles/ninety (90) minutes.

PARAMETER	DEFINITION AND SPECIFICATION
High Volume Specialty Care Provider – Adult	**Contract Standard:** Providers classified as Adult High Volume Specialty Care Providers for purposes of Time and Distances standards are the following: Cardiology, Dermatology, Endocrinology, Gastroenterology, Hematology, Oncology, Nephrology, Neurology, Orthopedic Surgery, Otolaryngology, Podiatry, Psychiatry, Pulmonology, Rheumatology, Surgery, and Urology. Enrollees living in Urban Areas must have one (1) of each type of Adult High Volume Specialty Care Provider within thirty (30) miles/sixty (60) minutes. Enrollees living in Non-Urban Areas must have one (1) of each type Adult High Volume Specialist within forty-five (45) miles/ninety (90) minutes.
High Volume Specialty Care Provider – Child	**Contract Standard:** Providers classified as Pediatric High Volume Specialty Care Providers for purposes of Time and Distance standards are the following: Allergy & Immunology, Cardiology, Dermatology, Endocrinology, Gastroenterology, Orthopedic Surgery, Otolaryngology, Pulmonology, Speech, Language and Hearing, and Surgery. Enrollees living in Urban Areas must have one (1) of each type Pediatric High Volume Specialty Care Provider within thirty (30) miles/sixty (60) minutes. Enrollees living in Non-Urban Areas must have one (1) of each type Pediatric High Volume Specialty Provider within forty-five (45) miles/ninety (90) minutes.
Adult and Pediatric Dental Providers	**Contract Standard:** Enrollees living in Urban Areas must have one (1) Dental Provider within thirty (30) miles/sixty (60) minutes. Enrollees living in Non-Urban Areas must have one (1) Dental Provider within forty-five (45) miles/ninety (90) minutes.
Met or Not Met	For each standard, indicate if the standard is met or not met as of the last day of the reporting period.
Reasons for Not Met	For each standard not met, describe the reason(s) the standard is not met. For each standard not met, the municipality and provider type must be identified in 16.E. **Rule Validations:** Mandatory field. If the standard is met, leave this field blank.
Total Providers Contracted	For each standard, indicate the number of providers/facilities contracted by the Contractor as a Plan Vital provider (with an approved agreement), as of the last day of the reporting period.
16.E T and D Municipality Non	
General	This section of the report monitors compliance with Section 9.4.4 of the contract.
Municipality	For each municipality and standard, indicate if all standards are met or not met. If met, enter “Met”. If not met, enter the number of enrollees without access for the relevant standard and municipality as of the last day of the reporting period.

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PARAMETER	DEFINITION AND SPECIFICATION
16.F Exceptions	
General	This section of the report monitors compliance with Section 9.4.2 of the contract.
Exception Requests	For each provider type, indicate if any exceptions were requested. Including any exceptions already submitted to ASES. If no exceptions are requested, enter "Met" in the relevant row. If an exception is requested, enter "Exception" in the relevant row. For all exceptions requested, ensure Attachment 15 has been submitted to ASES. If an exception request has already been submitted (Attachment 15), the Contractor is not required to resubmit Attachment 15.
16.G Addiction Medicine (include Buprenorphine Providers)	
General	For each provider contracted for Addiction Medicine, report the following values as of the last day of the reporting period: • NPI • Provider name • Specialty code • Addiction Medicine or Buprenorphine certification The values allowed for Addiction Medicine or Buprenorphine certification must be: • AD for Addiction Medicine or • BC for Buprenorphine Certification • AD/BC for both **Data Format**: Refer to the Data Field section associated with each field.

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Report 17 – Appointment Availability Report

Citrix Share link location:

CITRIX SHARE LOCATION
Compliance > 3-Quarterly

Purpose:

The Appointment Availability Report captures network assurance reviews and outreach to individual providers. The report should include a 25% review of the Contractor's provider network for the set of provider types assigned.

Submission Requirement:

The report is due on a quarterly basis and monitors the requirements 18.2 of the contract. The contractor must follow the onsite review schedule noted in 17.C.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
Definition	
General	This report captures the Contractor's quarterly network assurance reviews and outreach to individual Providers. This report captures a quarterly snap shot of network review activities done as part of the Contractor's annual network evaluation and monitoring plan. Each quarter the Contractor must review 25% of their network providers to query access and appointment standards. See 17.C for applicable review schedule. The review should include a representative sample of network providers by municipality. Any limitations or deficiencies should be noted in this list and any applicable corrective action/action plans described in 17.D.
Network Assurance Reviews	On a quarterly basis, the contractor must document network assurance reviews and outreach to individual Providers that cover 25% of network providers for the specified provider groupings. The review schedule for each Contractor is noted in 17.C.
17.A Review Detail	
General	This captures a list of providers where access and appointment availability reviews or visits were conducted by the Contractor during the reporting period.
Provider Name	Enter the name of the provider.
Provider NPI	Enter the national provider identifier of the provider. **Data Format**: Refer to the Data Field section associated with NPI.

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PARAMETER	DEFINITION AND SPECIFICATION
Provider Specialty Code	Enter the specialty code. Use provider types associated with the groups specified in the contract article 9.4. and must use the correct combination of group and provider type according to the following:

PCP - Adult

CODE	SPECIALTY	PROVIDER TYPE
01	General Practice	Primary Care Physician
08	Family Practice	Primary Care Physician
11	Internal Medicine	Primary Care Physician
16	Obstetrics / Gynecology	Gynecologist

PCP - Pediatric

CODE	SPECIALTY	PROVIDER TYPE
01	General Practice	Primary Care Physician
08	Family Practice	Primary Care Physician
37	Pediatric Medicine	Pediatrician

Specialist - Adult

CODE	SPECIALTY	PROVIDER TYPE
02	General Surgery	Surgeon
04	Otolaryngology	Otolaryngologist
06	Cardiology	Cardiologist
07	Dermatology	Dermatologist
10	Gastroenterology	Gastroenterologist
13	Neurology	Neurologist
14	Neurosurgery	Neurologist
20	Orthopedic Surgery	Surgeon
26	Psychiatry	Psychiatrist
27	Geriatric psychiatry	Psychiatrist
29	Pulmonary Diseases	Pneumologist
34	Urology	Urologist
39	Nephrology	Nephrologist
46	Endocrinology	Endocrinologist
48	Podiatry	Podiatrist
66	Rheumatology	Rheumatologist
82	Hematology	Hematologist
83	Hematology/Oncology	Oncologist
86	Neuropsychiatry	Psychiatrist
90	Medical Oncology	Oncologist
91	Surgical Oncology	Oncologist
92	Radiation Oncology	Oncologist

Specialist - Pediatric:

CODE	SPECIALTY	PROVIDER TYPE
02	General Surgery	Surgeon
03	Allergy/Immunology	Immunologist
04	Otolaryngology	Otolaryngologist
06	Cardiology	Cardiologist
07	Dermatology	Dermatologist
10	Gastroenterology	Gastroenterologist

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PARAMETER	DEFINITION AND SPECIFICATION
	15 Speech Language Pathologist in Private Practice — Other Physical Health Specialist 20 Orthopedic Surgery — Surgeon 29 Pulmonary Diseases — Pneumologist 46 Endocrinology — Endocrinologist
Municipality Code	Enter the municipality code for the provider location. Refer to the list of municipality codes of the Carrier to ASES Data Submissions-New File Layouts-Version 4.0B **Rule Validations:** Required.
Review Date	Enter the date the review and/or outreach was performed. **Data Format**: Refer to the Data Field section associated with Dates.
Review Type	Indicate the type of review conducted using one of the following codes as applicable: 1 = call survey, 2 = onsite visit, 3 = online survey, 4 = e-mail and 99 = other.
Enrollee Complaints	Enter Yes or No, if the Contractor received any complaints or grievances from Enrollees regarding access or appointment availability.
Appt. Av&T	Enter Yes or No, if there was a problem identified with appointment availability and timelines.
Address	Enter Yes or No, if the provider address was correct.
Phone	Enter Yes or No, if the provider phone number was correct.
E Mail	Enter Yes or No, if the provider E-Mail was correct.
Fax Number	Enter Yes or No, if the provider fax number was correct.
New patients	Enter Yes or No, if the provider is accepting new patients.
Limitations	Enter Yes or No, if the review noted any limitations with disability access, equipment or other limitations.
Languages	Enter the languages spoken at the provider office using the following codes as applicable 1 = Spanish, 2= English and/or 3 = Other. Only the code must be entered in the column identified.
Cultural Specific Training	Enter the name and date of any cultural specific training the provider participated in. If there is no training to report, leave the field blank.
17.B Appointment Standards	
Reference	Appointment standards as required in 9.5.1 of the contract. **Contract Standard:** <u>Urgent Conditions</u> Emergency Services – per 7.5.9 of the contract. Urgent Conditions Outpatient – 24 Hours

PARAMETER	DEFINITION AND SPECIFICATION
	Urgent Conditions Laboratory –48 Hours BH Crisis Services — 2 hours Detoxification services – Immediately according to clinical necessity Non-Urgent Conditions Routine Physical Exams – 30 Calendar Days Routine Physical Exams Less than 21 Years of Age – EPSDT Routine Evaluations for Primary Care – 30 Calendar Days Covered Services – 14 Calendar Days Specialist Services – 30 Calendar Days Dental Services – 60 Calendar Days BH Services – 14 Calendar Days Diagnostic/Laboratory Services Diagnostic Laboratory – 14 Calendar Days Diagnostic Imaging – 14 Calendar Days Other Testing Appointments – 14 Calendar Days Prescription Drugs Prescription Fills – In Person (ready for pick up) – 40 Minutes Prescription Fills – Phoned – 90 Minutes
17.C Review Schedule	
Review Schedule	The Contractor must review 25% of network providers per the schedule by provider type each reporting period. Behavioral health providers should be included with specialists. See Review Schedule table below.
17.D Limitations / Deficiencies	
NPI	Enter the national provider identification number. **Data Format**: Refer to Data Field section associated to NPI fields **Rule Validations:** Required field.
Comment	Each problem, deficiency, limitation or noncompliance identified with the provider.
Explanation of Action Plan	A summary of the action plan for each problem, deficiency, limitation or noncompliance identified with the provider.
17.E Notes	
Each Quarter	Any other comment or note

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Review Schedule

Specialists include Behavioral Health providers.				
Year 1				
MCO	Q1	Q2	Q3	Q4
First Medical	Specialists - Pediatric		PCP - Adult	PCP - Pediatric
MMM	Specialists - Adult	Specialists - Pediatric		PCP - Adult
Molina	PCP - Pediatric	Specialists - Adult	Specialists - Pediatric	
PSM	PCP - Adult	PCP - Pediatric	Specialists - Adult	Specialists - Pediatric
Triple S		PCP - Adult	PCP - Pediatric	Specialists - Adult
Year 2				
MCO	Q1	Q2	Q3	Q4
First Medical	Specialists - Adult	Specialists - Pediatric		PCP - Adult
MMM	PCP - Pediatric	Specialists - Adult	Specialists - Pediatric	
Molina	PCP - Adult	PCP - Pediatric	Specialists - Adult	Specialists - Pediatric
PSM		PCP - Adult	PCP - Pediatric	Specialists - Adult
Triple S	Specialists - Pediatric		PCP - Adult	PCP - Pediatric
Year 3				
MCO	Q1	Q2	Q3	Q4
First Medical	PCP - Pediatric	Specialists - Adult	Specialists - Pediatric	
MMM	PCP - Adult	PCP - Pediatric	Specialists - Adult	Specialists - Pediatric
Molina		PCP - Adult	PCP - Pediatric	Specialists - Adult
PSM	Specialists - Pediatric		PCP - Adult	PCP - Pediatric
Triple S	Specialists - Adult	Specialists - Pediatric		PCP - Adult

Report 18 – Provider Satisfaction Survey Report

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 5-Annually

Purpose:

The Provider Satisfaction Survey Report captures survey activities of Physical and Behavioral Health Network Providers.

Submission Requirement:

The report is due on an annual basis within 7 months after the end of the calendar year and monitors the requirements 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

The report has no prescribed format.

PARAMETER	DEFINITION AND SPECIFICATION
18.A Provider Satisfaction Survey Report	
Survey	There is no prescribed survey instrument for providers.
Survey Methods	Describe survey methods used to evaluate provider satisfaction.
Sample Size	The sample size must equal the number of respondents needed for a statistical confidence level of ninety-five percent (95%) with a margin of error not more than five percent (5%) and shall not have a response rate less than fifty percent (50%).
Survey Targeting	Define the types of providers/facilities targeted.
Findings	Describe the findings of the surveys completed. Physical health and Behavioral health providers should be reported separately.
Improvement Opportunities	Resulting from the surveys, describe area noted for improvement and any plans in place to make such improvements.

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Report 19 – Provider Training and Outreach Evaluation Report

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 3-Quarterly

Purpose:

The Provider Training and Outreach Evaluation Report captures network provider training initiatives, findings and lessons learned included in the Contractor's Provider Training and Outreach Plan.

Submission Requirement:

The report is due on a quarterly basis and monitors the requirements 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
19.A Training Activities	
Date	Enter the date of the activity or training. **Data Format**: Refer to Data Field section associated to Date fields
Training Topic	Enter the name of the activity/training performed during the reporting period.
Targeted Providers	Enter the provider specialty code who were targeted for the training. **Data Format**: Refer to Data Field section associated with the Provider Specialty Code as well as Appendix 3 of this Guide.
Total Education Hours	Enter the length of time of the activity/training that took place. For example: Hours number and minutes fraction format (5 hours 30 minutes = 5.50).
Training Method	Enter a description of the training method (i.e., face to face, webinar, other).
Funds Expended	Enter total cost of activity.
Invitations	Enter the total number of providers invited to participate in the training.
Attendees	Enter the total number of providers who participated in the training.
Attendance Rate	**Definition**: The percentage of invited providers who participated in the training activity. Data entry is not required. **Formula**: Attendees divided by invitations.
19.B Participating Providers	
Date	Enter the date of the activity or training.

PARAMETER	DEFINITION AND SPECIFICATION
Training Topic	Enter the name of the activity/training performed during the reporting period. This should correspond to the training topic listed in 19.A.
Provider Specialty Code	Enter the provider specialty code who participated in training during the reporting period. **Data Format**: Refer to Data Field section associated with the Provider Specialty Code as well as Appendix 3 of this Guide.
NPI	Enter the national provider identification number. **Data Format**: Refer to Data Field section associated to NPI **Rule Validations:** Optional field. If the PMG/facility does not have an NPI number, leave this field blank.
Total Education Hours	Enter the number of education hours that were awarded to the provider for participating in the training.
19.C Notes	
Narrative Question #1	For the training activities completed during the reporting period, describe how effective they were.
Narrative Question #2	Identify any lessons learned from one quarter to the next that lead to additional provider training activities.
Narrative Question #3	Specify any changes/modifications to the plan initially submitted to ASES and the reason.

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Report 20 – Physician Incentive Report

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 5-Annually

Purpose:

The Physician Incentive Report captures the Contractor's Physician Incentive Plan arrangements with providers and related details as required by federal guidance.

Submission Requirement:

The report is due on an annual basis within 90 days after the end of the calendar year and monitors the requirements 10.7, 18.2 and 23.6 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
20.A Physician Incentive Report	
Physician Incentive Plan/Report	Must comply with Federal and Puerto Rico regulations, including 42 CFR 422.208 and 422.210, and 42 CFR 438.3(i), and with the requirements in Sections 10.7, 18.2 and 23.6 of this Contract.
Provider Name	Enter the name of the provider for which a physician incentive plan is in place and reportable under the requirements of this report.
NPI	Enter the national provider identification (NPI) number for the listed provider. **Data Format**: Refer to Data Field section associated to NPI fields **Rule Validations:** Mandatory field.
Provider Specialty Code	Describe the type of specialty practice of the Provider. **Data Format**: Refer to Data Field section associated with the Provider Specialty Code as well as Appendix 3 of this Guide.
PMG	If applicable, provide the name of the Primary Medical Group (PMG) with which the listed provider has an agreement. **Rule Validations:** Optional field. If no PMG, leave this field blank.
Safeguards in Place to Ensure Medically Necessary Services are not Limited	Indicate 'Y' if the physician incentive plan has appropriate safeguards in place to ensure physicians under the arrangement are not incentivized to reduce or limit medically necessary services to members as described in 42 CFR 422.208 (c)(1), otherwise indicate 'N'.
Is Risk Transferred to the Provider	Indicate 'Y' if financial risk is transferred to the listed provider through the physician incentive plan, otherwise select 'N'. Financial risk includes any monetary incentive the provider is expected to receive, including unreturned withholds and downside risk from shared savings arrangements.

PARAMETER	DEFINITION AND SPECIFICATION
Type of Incentive Arrangement for Financial Risk	If 'Y' was indicated in bullet F, indicate the type of incentive arrangement that is in place related to the risk related to previous question, otherwise select 'None'. Note, for risk transferred to the provider for referrals, use bullets I-K.
Percentage of Risk	If 'Y' was indicated in bullet F, enter the percentage of potential payments reported in bullet P (and as defined in 42 CFR 422.208(a)) that is at risk under the physician incentive arrangement.
Is Risk Transferred to the Provider for Referral	Indicate 'Y' if financial risk is transferred for referral services to other providers through the physician incentive plan, otherwise indicate 'N'. For example, a bonus for low utilization of hospital, specialist or other services is considered to be a risk for referral services.
Type of Incentive Arrangement for Financial Risk	If 'Y' was indicated in bullet I, select the type of incentive arrangement that is in place for the risk related to referrals in bullet I, otherwise select 'None'.
Percentage of Risk	If 'Y' was indicated in bullet I, enter the percentage of potential payments reported in bullet P (and as defined in 42 CFR 422.208(a)) that is at risk for referrals under the physician incentive arrangement.
Number of Members Served by the Provider	Indicate the applicable range of members served by the listed Provider that are included under the relevant physician incentive plan.
Substantial Financial Risk	Using the guidance in 42 CFR 422.208(d), indicate 'Y' if the arrangement puts the listed Provider at substantial risk, if not, indicate 'N'. CMS considers providers to be at substantial financial risk when 25% or more of their potential managed care organization reimbursement depends on referrals they make or services they provide.
Stop Loss Insurance	If 'Y' was indicated in bullet M, indicate 'Y' if the Provider has the appropriate level of stop-loss insurance as defined in 42 CFR 422.208(f), if not indicate 'N'. If not applicable, indicate 'NA'.
Disclosure for Members	Indicate 'Y' if the required information available to distribute to members if requested (as defined by 42 CFR 422.210 (b)) has been provided to ASES, if not, indicate 'N'.
Potential Payments to Provider	Enter the amount of potential payments and as defined in 42 CFR 422.208(a) that is subject to the terms of the relevant physician incentive arrangement.
Description of Physician Incentive Plan	Enter a brief description of the physician incentive plan including applicable benchmarks, measures and any relevant information not included in other columns.

Report 21 – Grievances and Appeals Report

Citrix Share link location:

CITRIX SHARE LOCATION
Customer Service > 3-Quarterly

Purpose:

The Grievances and Appeals Report captures provider and enrollee Grievances (informal and formal), appeals, notices of adverse benefit determinations, administrative law hearings and enrollee web comments.

Submission Requirement:

The report is due on a quarterly basis and monitors the requirements 13.8 and 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
Definitions	
Administrative Law Hearing	The Appeal process administered by the Government and as required by Federal law, available to Enrollees after they exhaust the Contractor's Grievance and Appeal System.
Adverse Benefit Determination	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, requirements for medical necessity appropriateness, setting or effectiveness of a covered benefit; the denial, in whole or part, of payment for a service (including in circumstances in which an Enrollee is forced to pay for a service); the failure to provide services in a timely manner (within the timeframes established by this Contract or otherwise established by ASES); the failure of the Contractor to act within the timeframes provided in 42 CFR 438.408(b); or the denial of an Enrollee's request to dispute a financial liability, including cost-sharing, co-payments, premiums, deductibles, co-insurance, and other Enrollee financial liabilities.
Adverse Benefit Determination Notices	Notices for Adverse Benefit Determinations related to termination, suspension, or reduction of previously authorized Covered Services, at least ten (10) Calendar Days before the date of Adverse Benefit Determination. Notices may be mailed no later than the date of Adverse Benefit Determination, unless otherwise specified in the contract.
Appeal	An Enrollee request for a review of an Adverse Benefit Determination. It is a formal petition by an Enrollee, an Enrollee's Authorized Representative, or the Enrollee's Provider, acting on behalf of the Enrollee with the Enrollee's written consent, to reconsider a decision in the case that the Enrollee or Provider does not agree with an Adverse Benefit Determination taken.
Approved	Appeal determination fully reversing initial denial decision.

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PARAMETER	DEFINITION AND SPECIFICATION
Complaint	An expression of dissatisfaction about any matter other than an Adverse Benefit Determination that is resolved at the point of contact rather than through filing a formal Grievance.
Complaint Resolution	Resolve each Complaint within seventy-two (72) hours of the time the Contractor received the initial Complaint, whether orally or in writing. If the Complaint is not resolved within this timeframe, the Complaint shall be treated as a Grievance.
Grievance	An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. A Grievance may be filed by an Enrollee, Enrollee Representative or Provider on behalf of the Enrollee.
Grievance Receipt	Receipt of each Grievance in writing to the Enrollee (and the Provider, if the Provider filed the Grievance on the Enrollee's behalf) within ten (10) Business Days.
Grievance Disposition	Written notice of the disposition of the Grievance as expeditiously as the Enrollee's health condition requires, but in any event, within ninety (90) Calendar Days from the day the Contractor receives the Grievance.
Partially Denied	Appeal determination partially upholding initial denial decision. Also known as partial approvals.
Fully Denied	Appeal determination fully upholding initial denial decision.
Withdrawal/ Dismissal	Requests for appeals that were withdrawn or dismissed.
21.A Complaint, Grievance, ABD	
Section 1 – Enrollee Complaints (including received from OPP)	
General	This section captures enrollee/representative complaints received by the Contractor during the reporting period.
Total Received	Enter the total number of enrollee/representatives complaints received during the reporting period.
Processed	Enter the total number of enrollee/representatives complaints processed during the reporting period.
Resolved Within 72 Hours	Enter the total number of enrollee/representatives complaints resolved within 72 hours of receipt of the complaint during the reporting period.
Section 2 – Enrollee Grievances (including received from OPP)	
Opening Pending	Enter the total number of enrollee/representatives grievances that was open at the beginning of the reporting period. Note: Opening pending should be equal to the previous quarter closing pending.

PARAMETER	DEFINITION AND SPECIFICATION
Total Received	Enter the total number of enrollee/representatives grievances received during the reporting period.
Processed	**Definition**: The total number of enrollee/representatives grievances processed during the reporting period. Data entry is not required in this row. **Formula**: Processed by Reason for Physical Health + Processed by Reason for Behavioral Health.
Receipt In Writing in 10 Days (From Processed)	Enter the number of receipts sent in writing to enrollees within 10 business days for grievances processed during the reporting period.
Disposition Notice in 90 Days	Enter the number of disposition notices sent in writing to enrollees within 90 calendar days for grievances processed during the reporting period.
Pending at the End of Quarter (Closing Pending)	**Definition**: The total number of enrollee/representatives grievances pending resolution at the end of the reporting period. Data entry is not required. **Formula**: Opening Pending + Total Received – Processed.
Processed by Reason for Physical Health	**Definition** The total sum of enrollee/representatives grievances processed by type, pertaining to physical health services, at the end of the reporting period. Data entry is not required. **Formula:** The sum of enrollee/representative grievances by type of grievance for physical health services.
Processed by Reason for Behavioral Health	**Definition** The total sum of enrollee/representatives grievances processed by type, pertaining to behavioral health services, at the end of the reporting period. Data entry is not required. **Formula:** The sum of enrollee/representative grievances by type of grievance for behavioral health services.

PARAMETER	DEFINITION AND SPECIFICATION
Processed by Reason	Separately for physical health and behavioral services, enter the number of grievances processed which correspond to one or more of the following reasons: Access or Delay of Services Appointment Standard Availability/Timeliness Co-Pay/Deductible Customer Service Issue Dissatisfaction w/ PCP Dissatisfaction w/ Contractor Hazardous Environment Conditions HIPAA violations Inappropriate Behavior by Provider/Staff Member Network Availability of Services Pharmacy In-Office Waiting Times Quality of Medical Service Quality of Office/Facility (Equipment/Environment etc.) Services/Procedures Denied or Reduced Plan or provider care management/case management issues (Include grievances about the timeliness of an assessment or complaints about the plan or provider care or case management process.) Plan Communications Payment or billing issues Suspected fraud Abuse/neglect/exploitation Lack of timely plan response to a service authorization or appeal request Plan denial of request for an expedited appeal Per 42 CFR §438.408(b)(3) Other
Grievances by service type	Enter the number of grievances resolved which correspond to one or more of the following service types: General inpatient services General outpatient services Inpatient behavioral health services Outpatient behavioral health services Covered outpatient prescription drugs Skilled nursing facility (SNF) services Dental services Non-emergency medical transportation (NEMT) Other
Section 3 – Provider Complaints, Grievances, and or Disputes	
General	This section captures complaints, grievances and or disputes made by providers to the Contractor during the reporting period.
Opening Pending	Enter the total number of provider complaints, grievances and or disputes that was open at the beginning of the reporting period. Note: Opening pending should be equal to the previous quarter closing pending.

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PARAMETER	DEFINITION AND SPECIFICATION
Total Received	Enter the total number of provider complaints, grievances and or disputes received during the reporting period.
Processed	**Definition**: The total number of provider complaints, grievances and or disputes processed during the reporting period. Data entry is not required. **Formula**: Physical Health Provider Reasons + Behavioral Health Provider Reasons.
Pending at the End of Quarter (Closing Pending)	**Definition**: The total number of provider complaints, grievances and or disputes pending resolution at the end of the reporting period. Data entry is not required. **Formula**: Opening Pending + Total Received – Processed.
Physical Health Providers	**Definition** The total sum of provider complaints, grievances and or disputes by type, pertaining to physical health providers, at the end of the reporting period. Data entry is not required. **Formula:** The sum of provider grievances and disputes by type of grievance for physical health providers.
Behavioral Health Providers	**Definition** The total sum of provider complaints, grievances and or disputes by type, pertaining to behavioral health providers, at the end of the reporting period. Data entry is not required. **Formula:** The sum of provider grievances and disputes by type of grievance for behavioral health providers.
Provider Complaints, Grievances, Disputes Reasons	Enter the number of provider complaints, grievances and or disputes processed which correspond to one or more of the following reasons: Claims Processing Contract Issues Diagnosis Treatment Disagreement Payment Pharmacy Services/Procedures Denied or Reduced UM Denial – Non Rx UM Denial – Rx Other
Section 4 – Requests from Health Advocate	
Received	Enter the total number of requests for a health advocate (Oficina del Procurador del Paciente (OPP) received during the reporting period.
Processed	Enter the total number of requests for a health advocate (Oficina del Procurador del Paciente (OPP) processed during the reporting period.

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PARAMETER	DEFINITION AND SPECIFICATION
Pending at the End of Quarter (Closing Pending)	Enter the total number of requests for a health advocate (Oficina del Procurador del Paciente (OPP) pending at the end of the reporting period.
Section 5 – Notice of Adverse Benefit Determinations	
Number of Notices Sent	Enter the total number of notices processed for enrollees with an adverse benefit determination during the reporting period.
10 Day Notices for Termination, Suspension, Reduction	Of the total number of Adverse Benefit Determinations sent, enter the number of notices sent that pertain to a termination, suspension or reduction of services/treatment that are due to be sent 10 days before the determination.
Notices Sent with Adverse Benefit Determination	Of the total number of Adverse Benefit Determinations sent, enter the number of notices sent when the determination was made. This should not include notices for termination, suspension and or reduction of services.
21.B Appeals	
Section 1 – Appeals	
General	This section of the report captures appeals made by enrollees, enrollee representatives or providers on behalf of an enrollee for Adverse Benefit Determinations.
Opening Pending	Enter the total number of appeals that was open at the beginning of the reporting period. Note: Opening pending should be equal to the previous quarter closing pending.
Total Received	Enter the total number of appeals received during the reporting period.
Processed	**Definition**: The total number of appeals processed during the reporting period. Data entry is not required. **Formula**: Processed by Reason for Physical Health + Processed by Reason for Behavioral Health.
Expedited Disposition Notice in 72 Hours	Of the number of appeals processed, enter the number of appeals that were expedited (with a disposition notice within 72 hours of receipt) during the reporting period.
Disposition Notice in 30 Days	Of the number of appeals processed, enter the number of appeals where the disposition notice was issued within 30 days of receipt during the reporting period.
Extension Requested For Resolution	Of the number of appeals processed, enter the number appeals where the disposition notice timeframe was extended (up to 14 calendar days) with the Enrollee's written consent, during the reporting period.

PARAMETER	DEFINITION AND SPECIFICATION
Pending at the End of Quarter (Closing Pending)	**Definition:** The total number of enrollee/representatives appeals pending resolution at the end of the reporting period. Data entry is not required. **Formula**: Opening Pending + Total Received – Processed.
Processed Determinations	**Definition:** The total number of appeals processed (by determination) during the reporting period. Data entry is not required. **Formula**: The sum of determinations made for processed appeals.
Approved	Of the number of appeals processed, enter the number of Adverse Benefit Determinations that were fully overturned on appeal.
Partially Denied	Of the number of appeals processed, enter the number of Adverse Benefit Determinations that were partially overturned on appeal.
Fully Denied	Of the number of appeals processed, enter the number of Adverse Benefit Determinations that upheld the initial denial decision following appeal.
Withdrawals/ Dismissals	Of the number of appeals processed, enter the number of appeals that were withdrawn or dismissed that did not complete the appeals process.
Processed Appeal Reasons Physical Health	**Definition** The total sum of physical health service appeals processed by type of appeal (reason) during the reporting period. Data entry is not required. **Formula:** The sum of appeal types processed for physical health services.
Processed Appeal Reasons Behavioral Health	**Definition** The total sum of behavioral health service appeals processed by type of appeal (reason) during the reporting period. Data entry is not required. **Formula:** The sum of appeal types processed for behavioral health services.
Processed Appeal Reasons	Separately for physical health and behavioral health services, enter the number of appeals processed which correspond to one or more of the following reasons: Denial or limited authorization of a requested service (including the type or level of service). Denial in part of a payment for a service. Denial in whole of a payment for a service. Failure of Contractor to complete the authorization request within specific timeframes (as set forth in 42 C.F.R. § 438.408). Failure of Contractor to provide authorized services in a timely manner (as defined by the State or its designee). Reduction of a previously authorized service. Suspension of a previously authorized service. Termination of a previously authorized service.

PARAMETER	DEFINITION AND SPECIFICATION
	Denial of an enrollee's right to request out-of-network care Denial of an enrollee's request to dispute financial liability Other
Appeals resolved by service type	Enter the number of appeals resolved which correspond to one or more of the following service types: General inpatient services General outpatient services Inpatient behavioral health services Outpatient behavioral health services Covered outpatient prescription drugs Skilled nursing facility (SNF) services Dental services Non-emergency medical transportation (NEMT) Other
Section 2 – Administrative Law Hearings	
Requests Received	Enter the total number of requests for an Administrative Law Hearing received during the reporting period.
Section 3 – Requests from Health Advocate	
Received	Enter the total number of requests for a health advocate (Oficina del Procurador del Paciente (OPP) received during the reporting period.
Processed	Enter the total number of requests for a health advocate (Oficina del Procurador del Paciente (OPP) processed during the reporting period.
Pending at the End of Quarter (Closing Pending)	Enter the total number of requests for a health advocate (Oficina del Procurador del Paciente (OPP) pending at the end of the reporting period.
21.C Web Comments	
Analysis	List the top five (5) issues (grievances, complaints) that were received during the reporting period through the Contractor's portal/comments tracker. In the free text space, elaborate on each of the issues provided.

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Report 22 – Health Care Improvement Program (HCIP) Report

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 3-Quarterly

Purpose:

Report 22, the Health Care Improvement Program (HCIP) Report template captures quarterly performance on the scored measures listed within the parameter section below. The scored measures drive the Retention Fund reimbursement and the benchmark for each measure is established by ASES. Each fiscal year, the quality measures required to be reported for the HCIP will be communicated by ASES. The complete list of quality measures are listed in Attachment 19 – Health Care Improvement Program Manual for reference.

Coding specifications for each parameter is located within the Year 3 Code Book I Health Care Improvement Program Manual and/or HCIP Year 3 ASES Diagnosis.

ASES shall maintain a retention fund created by withheld amounts of the PMPM payment each month as part of the HCIP described in Section 22.4 of the Contract. The retained PMPM amount shall be associated with the HCIP initiatives outlined below:

1. High Cost Conditions Initiative
2. Chronic Conditions Initiative
3. Healthy People Initiative
4. Emergency Room High Utilizers Initiative

Submission Requirement:

The report is due on a quarterly basis and monitors the requirements of 12.5 and 18.2 of the contract.

PERIOD	CLAIMS DATA: INCURRED SERVICE TIME PERIOD – START	CLAIMS DATA: INCURRED SERVICE TIME PERIOD – END	SUBMISSION DUE DATE TO ASES
Year 1			
Q1	January 1, 2018	December 31, 2018	July 30, 2019
Q2	April 1, 2018	March 31, 2019	July 30, 2019
Q3	July 1, 2018	June 30, 2019	October 30, 2019
Q4	October 1, 2018	September 30, 2019	January 30, 2020

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PERIOD	CLAIMS DATA: INCURRED SERVICE TIME PERIOD – START	CLAIMS DATA: INCURRED SERVICE TIME PERIOD – END	SUBMISSION DUE DATE TO ASES
Year 2			
Q1	January 1, 2019	December 31, 2019	April 30, 2020
Q2	April 1, 2019	March 31, 2020	July 30, 2020
Q3	July 1, 2019	June 30, 2020	October 30, 2020
Q4	October 1, 2019	September 30, 2020	January 30, 2021
Year 3			
Q1	January 1, 2020	December 31, 2020	May 31, 2021
Q2	April 1, 2020	March 31, 2021	July 30, 2021
Q3	July 1, 2020	June 30, 2021	October 30, 2021
Q4	October 1, 2020	September 30, 2021	January 30, 2022

Parameters: All fields are required if no other specific instructions are detailed for each field.

The parameters and metrics for this report are outlined in the table below and in Report 22 Health Care Improvement Program, Code Book II, which includes coding specifications to identify HCIP populations and Report 22, HCIP Template.

For each section, the values sent must be associated to respective defined type and measure. Different combinations will not be accepted. All sections must be included and have values.

PARAMETER	DEFINITION AND SPECIFICATION
22. HCC Initiative Medicaid Federal – High Cost Conditions Report Eligibility Criteria: All Medicaid Federal eligible members	
Cancer - Scored measure: Readmissions rate	**Numerator:** Number of readmissions within 30 days of inpatient discharge from Medicaid Federal eligible members with a principal cancer diagnosis (refer to HCIP Year 3 ASES Diagnosis Codes) during the measurement period. **Denominator:** Number of inpatient discharges from all Medicaid Federal eligible members identified with principal cancer diagnosis (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Rate =** Numerator / Denominator. Data entry is not required.

PARAMETER	DEFINITION AND SPECIFICATION
Cancer - Scored measure: PHQ-9	**Numerator:** Number of Medicaid Federal eligible members identified with a principal cancer diagnosis (refer to HCIP Year 3 ASES Diagnosis Codes) who were screened with a PHQ-9 test during the measurement period. **Denominator:** All Medicaid Federal eligible members identified with a principal cancer diagnosis (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
End-Stage Renal Disease (ESRD) - Scored measure: Admissions/1000	**Numerator:** Number of inpatient discharges from Medicaid Federal eligible members with a principal ESRD diagnosis (refer to HCIP Year 3 ASES Diagnosis Codes) during the measurement period. Excludes obstetric admissions and transfers from other institutions. * 1000 (formula will multiply) **Denominator:** All Medicaid Federal eligible members identified with a principal ESRD diagnosis during a rolling 12-month lookback period. **Rate = (**Numerator / Denominator)*1000. Data entry is not required.
End-Stage Renal Disease (ESRD - Scored Measure: PHQ-9	**Numerator:** Number of Medicaid Federal eligible members identified with ESRD (refer to HCIP Year 3 ASES Diagnosis Codes) who were screened with a PHQ-9 test during the measurement period. **Denominator:** All Medicaid Federal eligible members identified with ESRD diagnosis on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
Multiple Sclerosis (MS) - Scored Measure: Admissions/1000	**Numerator:** Number of inpatient discharges for Medicaid Federal eligible members with a principal MS diagnosis (refer to HCIP Year 3 ASES Diagnosis Codes) of MS during the measurement period. Excludes obstetric admissions and transfers from other institutions. * 1000 (formula will multiply) **Denominator:** All Medicaid Federal eligible members identified with a principal MS diagnosis (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Rate = (**Numerator / Denominator)*1000. Data entry is not required.
22. HCC Initiative CHIP – High Cost Conditions Report Eligibility Criteria: All CHIP eligible members	
Cancer - Scored Measure: Readmissions rate	**Numerator:** Number of readmissions within 30 days for CHIP eligible members with a principal cancer diagnosis (refer to HCIP Year 3 ASES Diagnosis Codes) during the measurement period. **Denominator:** Number of inpatient discharges for CHIP eligible members identified with a principal cancer diagnosis (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Rate =** Numerator / Denominator. Data entry is not required.
Children and Youth with Special Healthcare Needs (CYSHCN) Scored Measure: Child and	**Numerator:** Number of CHIP eligible members identified as CYSHCN based on all diagnosis code positions (refer to HCIP Year 3 ASES Diagnosis Codes) with one or more well-child visits in the 3-21 years of life on a rolling 12-month lookback period. Note: Refer to HEDIS 2019 Volume 2 for more detailed specifications including the types of acceptable visits.

PARAMETER	DEFINITION AND SPECIFICATION
Adolescent Well-care Visits (WCV)	**Denominator:** All CHIP eligible members identified as CYSHCN (refer to HCIP Year 3 ASES Diagnosis Codes) 3-21 years of age on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
CYSHCN | Scored Measure: Annual Dental Visits (ADV)	**Numerator**: Number CHIP eligible members identified as CYSHCN based on all diagnosis code positions (refer to HCIP Year 3 ASES Diagnosis Codes) who had at least one dental visit made during the rolling 12-month lookback period. **Denominator:** All CHIP eligible members identified as CYSHCN (refer to HCIP Year 3 ASES Diagnosis Codes) with dental benefits on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
Autism - Scored Measure: Child and Adolescent Well-care Visits (WCV)	**Numerator:** Number of CHIP eligible members identified with Autism based on all diagnosis code positions (refer to HCIP Year 3 ASES Diagnosis Codes) with one or more well-child visits in the 3-21 years of life on a rolling 12-month lookback period. Note: Refer to HEDIS 2019 Volume 2 for more detailed specifications including the types of acceptable visits. **Denominator:** All CHIP eligible members identified with Autism (refer to HCIP Year 3 ASES Diagnosis Codes) 3-21 years of age on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
22. CCI Medicaid Federal- Chronic Conditions Report	
Diabetes (Including CHIP population) - Scored measure: Comprehensive Diabetes Care: HbA1c	**Numerator:** Number of Medicaid Federal eligible members ages 18-75 years of age identified with diabetes based on all diagnosis code positions (refer to HCIP Year 3 ASES Diagnosis Codes) that had an HbA1c test completed on a rolling 12-month lookback period. **Denominator:** All Medicaid Federal eligible members identified with diabetes based on all diagnosis code positions (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
Diabetes (Including CHIP population) - Scored measure: Comprehensive Diabetes Care: Eye Exam	**Numerator:** Number of Medicaid Federal eligible members ages 18-75 years of age identified with diabetes based on all diagnosis code positions (refer to HCIP Year 3 ASES Diagnosis Codes) that had an eye exam completed on a rolling 12-month lookback period. **Denominator:** All Medicaid Federal eligible members identified with diabetes (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
Diabetes (Including CHIP population) - Scored measure: Kidney Health Evaluation for Patients with Diabetes (KED)	**Numerator:** Number of Medicaid Federal eligible members ages 18-85 identified with diabetes based on all diagnosis code positions (refer to HCIP Year 3 ASES Diagnosis Codes) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) on a rolling 12-month lookback period. **Denominator:** All Medicaid Federal eligible members identified with diabetes (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.

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PARAMETER	DEFINITION AND SPECIFICATION
Diabetes (Including CHIP population) - Scored measure: Admissions/1000	**Numerator:** Number of inpatient discharges for Medicaid Federal eligible members with a principal diagnosis of diabetes (refer to HCIP Year 3 ASES Diagnosis Codes) during the measurement period. Excludes obstetric admissions and transfers from other institutions. * 1000 (formula will multiply) **Denominator:** All Medicaid Federal eligible members identified with diabetes based on all diagnosis code positions (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Rate =** (Numerator / Denominator)*1000. Data entry is not required.
Asthma (Including CHIP) | Scored Measure: Admission/1000	**Numerator:** Number of inpatient discharges for Medicaid Federal eligible members with a principal diagnosis (refer to HCIP Year 3 ASES Diagnosis Codes) of asthma during the measurement period. * 1000 (formula will multiply) **Denominator:** All Medicaid Federal eligible members identified with asthma (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Rate =** (Numerator / Denominator)*1000. Data entry is not required.
Asthma (Including CHIP) - Scored Measure: Emergency Department (ED) Use/1000	**Numerator:** Number of ED visits for Medicaid Federal eligible members with a principal diagnosis (refer to HCIP Year 3 ASES Diagnosis Codes) of asthma during the measurement period. * 1000 (formula will multiply) **Denominator:** All Medicaid Federal eligible members identified with asthma (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Rate =** (Numerator / Denominator)*1000. Data entry is not required.
Asthma (Including CHIP) - Scored Measure: PHQ-9	**Numerator:** Number Medicaid Federal eligible members identified with asthma (refer to HCIP Year 3 ASES Diagnosis Codes) who were screened with a PHQ-9 test during the measurement period. **Denominator:** All Medicaid Federal eligible members identified with asthma (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
Severe Heart Failure - Scored Measure: Admissions/1000	**Numerator:** Number of inpatient discharges for Medicaid Federal eligible members with a principal diagnosis of severe heart failure (refer to HCIP Year 3 ASES Diagnosis Codes) during the measurement period. Excludes obstetric admissions and transfers from other institutions. * 1000 (formula will multiply) **Denominator:** All Medicaid Federal eligible members identified with severe heart failure (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Rate =** (Numerator / Denominator)*1000. Data entry is not required.
Severe Heart Failure - Scored Measure: PHQ-9	**Numerator:** Number Medicaid Federal eligible members identified with severe heart failure (refer to HCIP Year 3 ASES Diagnosis Codes) who were screened with a PHQ-9 test during the measurement period. **Denominator:** All Medicaid Federal eligible members identified with severe heart failure (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.

PARAMETER	DEFINITION AND SPECIFICATION
Hypertension - Scored Measure: ED Use/1000	**Numerator:** Number of ED visits for Medicaid Federal eligible members 18 years of age and older with a principal diagnosis of hypertension (refer to HCIP Year 3 ASES Diagnosis Codes) during the measurement period. * 1000 (formula will multiply) **Denominator:** All Medicaid Federal eligible members identified with hypertension (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Rate =** (Numerator / Denominator)*1000. Data entry is not required. Coding Specifications: Refer to HCIP Program Code Book I
Chronic Obstructive Pulmonary Disease (COPD) - Scored Measure: Admissions/1000	**Numerator:** Number of inpatient discharges for Medicaid Federal eligible members with a principal diagnosis of COPD (refer to HCIP Year 3 ASES Diagnosis Codes), during the measurement period. Excludes obstetric admissions and transfers from other institutions. * 1000 (formula will multiply) **Denominator:** All Medicaid Federal eligible members identified with COPD (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Rate =** (Numerator / Denominator)*1000. Data entry is not required.
Chronic Depression - Scored Measure: Follow up after Hospitalization for Mental Illness (FUH): 7 days	**Numerator:** Number of Medicaid Federal eligible members identified with a principal diagnosis of chronic depression (refer to HCIP Year 3 ASES Diagnosis Codes), that had a follow up seven days after hospitalization for mental illness during the measurement period. **Denominator:** All Medicaid Federal eligible members identified with chronic depression condition that were discharged during the measurement period. **Percent =** Numerator / Denominator. Data entry is not required.
Chronic Depression - Scored Measure: Follow up after Hospitalization for Mental Illness (FUH): 30 days	**Numerator:** Number of inpatient discharges during the measurement period for Medicaid Federal eligible members identified with chronic depression (refer to HCIP Year 3 ASES Diagnosis Codes) that had a follow up visit within thirty days after hospitalization. **Denominator:** All Medicaid Federal eligible members identified with chronic depression (refer to HCIP Year 3 ASES Diagnosis Codes) that were discharged during the measurement period. **Percent =** Numerator / Denominator. Data entry is not required.
Chronic Depression - Scored Measure: Inpatient Admissions/1000	**Numerator:** Number of inpatient discharges for Medicaid Federal eligible members with a principal diagnosis (refer to HCIP Year 3 ASES Diagnosis Codes) of chronic depression during the measurement period. Excludes obstetric admissions and transfers from other institutions. * 1000 (formula will multiply) **Denominator:** All Medicaid Federal eligible members identified with chronic depression (refer to HCIP Year 3 ASES Diagnosis Codes) on a rolling 12-month lookback period. **Rate =** (Numerator / Denominator)*1000. Data entry is not required.

PARAMETER	DEFINITION AND SPECIFICATION
22. Healthy People Initiative- Healthy People Initiative Report Eligibility Criteria: All Medicaid eligible members All visit types, screenings and medication identification are defined according to HEDIS specifications metrics.	
Breast Cancer Screening (BCS)	**Numerator:** Number of BCSs conducted from Medicaid eligible members on a rolling 12-month lookback period. **Denominator:** All Medicaid eligible females 50-74 years of age during the rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
Cervical Cancer Screening (CCS)	**Numerator:** Number of CCSs conducted from Medicaid eligible members on a rolling 12-month lookback period. **Denominator:** All Medicaid eligible females 21-64 years of age during the rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
Controlling High Blood Pressure (CBP)	**Numerator:** Number of identified members with a numerator compliant BP reading (BP <140/90 mm Hg). Readings to take place on or after the date of the 2^{nd} diagnosis. Data used from Medicaid eligible members during the rolling 12-month lookback period. **Denominator:** All Medicaid eligible members 18-85 years of age with a diagnosis of hypertension during the rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD)	**Numerator:** Medicaid eligible adults 18–64 years of age with schizophrenia or bipolar disorder (refer to HEDIS for diagnostic codes), who were dispensed an antipsychotic medication and had a diabetes screening test during the rolling 12-month lookback period. **Denominator:** All Medicaid eligible adults 18–64 years of age with schizophrenia or bipolar disorder (refer to HEDIS for diagnostic codes) on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
Follow-Up After Hospitalization for Mental Illness (FUH) 30 days	**Numerator:** Number of inpatient discharges during the measurement period for Medicaid eligible members diagnosed with mental illness (refer to HEDIS for diagnostic codes) that had a follow up visit thirty days after hospitalization during the rolling 12-month lookback period. **Denominator:** All Medicaid eligible members identified with mental illness (refer to HEDIS for diagnostic codes) that were discharged during the measurement period. **Percent =** Numerator / Denominator. Data entry is not required.
Adults Access to Preventive/Ambulatory Health Services (AAP)	**Numerator:** Number of Medicaid eligible members 20 years or older who had an ambulatory or preventative care visit during the rolling 12-month lookback period **Denominator:** All Medicaid eligible members 20 years of age or older on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
Annual Dental Visit (ADV)	**Numerator:** Number of Medicaid eligible members 2-20 years of age who had at least one dental visit made during the rolling 12-month lookback period.

PARAMETER	DEFINITION AND SPECIFICATION
	Denominator: All Medicaid eligible members 2-20 years of age with dental benefits on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
Timeliness of Prenatal Care (PPC)	**Numerator:** Number of deliveries that received a prenatal care visit as a Medicaid eligible member during the first trimester during the rolling 12-month lookback period **Denominator:** Number of deliveries from all Medicaid eligible members on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
Postpartum Care (PPC)	**Numerator:** Number deliveries that had a postpartum visit on or between 21 and 56 days after delivery from Medicaid eligible members during the rolling 12-month lookback period **Denominator:** Number of deliveries on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
Child and Adolescent Well-Care Visits (WCV)	**Numerator:** Number of Medicaid eligible child and adolescents 3-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the rolling 12-month lookback period. **Denominator:** Child and adolescents 3-21 years of age on a rolling 12-month lookback period. **Percent =** Numerator / Denominator. Data entry is not required.
22. Emergency Room (ER) High Utilizers Initiative	
Overall ER utilization rate x 1000 on identified population with 7 or more visits to the Emergency Room	**Numerator:** Total number of ER visits incurred by Medicaid eligible members with seven or more ER visits within the measurement period. **Denominator:** All Medicaid eligible members within the measurement period. **Rate = (**Numerator / Denominator)* 1000. Data entry is not required.

Report 23 – Enrollee Satisfaction Survey Report

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 5-Annually

Purpose:

The Enrollee Satisfaction Survey Report captures a summary of the Enrollee survey methods, findings, analysis and evaluation.

Submission Requirement:

The report is due on an annual basis 7 months after the end of the calendar year and monitors the requirements of 12.7 and 18.2 of the contract. The report must present information separately for CAHPS and ECHO. The survey and findings shall be presented by populations as determined by ASES (e.g., Adults, children, Behavioral Health and Chronic Conditions). The report must provide an action plan addressing areas for improvement of the Contractor as identified in the survey results.

Parameters: All fields are required if no other specific instructions are detailed for each field.

The report has no prescribed format.

PARAMETER	DEFINITION AND SPECIFICATION
23.A Enrollee Satisfaction Survey Report	
Survey	The survey for Enrollees shall be the Consumer Assessment of Health Care Providers and Systems ("CAHPS") and the Experience of Care and Health Outcomes ("ECHO") survey instruments.
Sample Size	The sample size must equal the number of respondents needed for a statistical confidence level of ninety-five percent (95%) with a margin of error not more than five percent (5%) and shall not have a response rate less than fifty percent (50%).
Sample Size	The sample size for both surveys shall equal the number of respondents needed for a statistical confidence level of ninety-five percent (95%) with a margin of error not more than five percent (5%) and shall not have a response rate less than fifty percent (50%).
Survey Methods	Describe survey methods used to evaluate enrollee satisfaction.
Survey Targeting	Define the types of enrollees targeted.
Findings	Describe the findings of the surveys completed. Enrollees with physical health and behavioral health conditions should be reported separately.
Improvement Opportunities	Resulting from the surveys, describe area noted for improvement and any plans in place to make such improvements.

Report 24 – Audited HEDIS Results Report

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 5-Annually

Purpose:

The Audited HEDIS Results Report captures NCQA published HEDIS standardized measures that specify how MCOs collect, audit, calculate and report performance information. Required measures are outlined in the HCIP and Quality Management Strategy.

Submission Requirement:

The report is due on an annual basis within 7 months after the end of the calendar year and monitors the requirements of 12 and 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

The report must be submitted following the instructions reflected in the last normative letter from ASES. An XSD is provided to report this information through XML format.

HEDIS MY 2020 & MY 2021, Volume 2 technical specifications

Effectiveness of Care:

- Asthma Medication Ratio (AMR)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Chlamydia Screening in Women (CHL)
- Controlling High Blood Pressure (CBP)
- Comprehensive Diabetes Care (CDC)
- Kidney Health Evaluation for Patients with Diabetes (KED)
- Antidepressant Medication Management (AMM)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Appropriate Treatment for Children With Upper Respiratory Infection (URI)

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Access/Availability of Care:

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Annual Dental Visit (ADV)
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
- Prenatal and Postpartum Care (PPC)

Utilization:

- Well-Child Visits in the First 30 Months of Life (W30)
- Child and Adolescent WellCare Visits (WCV)
- Frequency of Selected Procedures (FSP)
- Ambulatory Care (AMB)
- Identification of Alcohol and Other Drug Services (IAD)
- Mental Health Utilization (MPT)
- Plan All-Cause Readmissions (PCR)

Report 25 – Utilization Management and Integration Model Report

Citrix Share link location:

CITRIX SHARE LOCATION
Planning, Quality & Clinical Affairs > 3-Quarterly

Purpose:

The Utilization Management and Integration Model Report captures summarized data for select GHP populations and providers on utilization and integrated care including; services by collocated and reverse collocation, educational activities that took place for beneficiaries and providers, program specific data for care management, both pregnancy and non-pregnancy, smoking cessation, autism, attention deficit disorder and buprenorphine treatment.

Submission Requirement:

The report is due on a quarterly basis and monitors the requirements of 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

The data submitted within this report is exclusive to each quarter. Updates should not be made to data submitted for a previous quarter.

PARAMETER	DEFINITION AND SPECIFICATION
Definitions	
Enrollee	A person who is currently enrolled in the Contractor's GHP Plan, as provided in this Contract, and who, by virtue of relevant Federal and Puerto Rico laws and regulations, is an Eligible Person listed in Section 1.3.1 of the Contract.
Enrollees by Age Group	The number of enrollees enrolled in the Contractor's GHP Plan at the end of the reporting quarter. The enrollees are reported by four distinct age groups: 0-21 years, 22-39 years, 40-64 years and 65+ years, based on the enrollee's age on the last day of the reporting period.
Preventable Conditions	Preventable Conditions per 7.1.1.1.1 and 7.1.1.1.2 of the contract are defined as: All hospital acquired conditions as identified by Medicare other than deep vein thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients for inpatient hospital services; and any incorrect surgical or other invasive procedure performed on a patient; any surgical or other invasive procedure performed on the incorrect body part; or any surgical or other invasive procedure performed on the incorrect patient for inpatient and non-institutional services.
25.A Services by Collocated Entity	
PMG Identifier	Enter the identification number of the PMG.
PMG Name	Enter the name or title of the PMG.

PARAMETER	DEFINITION AND SPECIFICATION
NPI	Enter the national provider identification number. **Data Format**: Refer to Data Field section associated to NPI field **Rule Validations:** Required field. If the PMG does not have an NPI number, leave this field blank.
Enrollees	Enter the total number of enrollees registered with the PMG (by assignment or selection) as of the last day of the report period. This number should include the sum of all office locations of providers in the PMG. **Rule Validations:** Optional field If enrollees are not assigned/selected to a specific PMG, leave this field blank.
Required Quarterly Hours	Enter the number of quarterly hours required for co-location, based on the weekly hours required per amount of enrollees as per Attachment 10 of the contract: Co-location Guidelines. **Data Format**: Refer to Data Field section associated to hours and minutes fields
Actual Qtr. Hours of Collocated	Enter the actual quarterly hours being provided by collocated provider(s). Any deviation under or over required hours must be explained in 25.H. **Data Format**: Refer to Data Field section associated to hours and minutes fields
Co-location Hours Compliance (Yes or No)	Indicate Yes or No, if the co-located hours requirement is in compliance based on the amount of enrollees assigned to the PMG. (Refer to Attachment 10 of the contract: Co-location Guidelines.)
Unique Enrollees seen by the PMG	Enter the number of unique enrollees rendered services at the PMG during the reporting period.
Unique Enrollees Served by Collocated	Enter the number of unique enrollees served by a collocated provider(s) at the PMG during the reporting period.
Total Number of Services Rendered	Enter the total number of services rendered during the reporting period.
Initial Assessments by Collocated	Enter the total number of initial assessments performed by collocated providers during the reporting period.
Short Intervention	Enter the number of unique enrollees that received short intervention by collocated providers during the reporting period.
Case Discussion	Enter the number of unique enrollees who had their case discussed between a PCP/OBGYN and behavioral health provider during the reporting period.
Referrals to BH Providers	Enter the number of referrals made to Behavioral Health Providers other than a collocated provider during the reporting period.
Referrals to CM	Enter the number of referrals made for care management by any member of the PMG team during the reporting period.

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PARAMETER	DEFINITION AND SPECIFICATION
Percent of Enrollees Seen by Collocated	**Definition**: The percentage of enrollees seen by a collocated provider at the PMG during the reporting period. Data entry is not required. **Formula**: Unique enrollees served by collocation divided by unique enrollees seen by the PMG within the reporting period.
AVG Hour per Enrollee	**Definition**: The average actual hours used by enrollees who were served at the PMG during the reporting period. Data entry is not required. **Formula**: Actual Qtr. Hours of Collocated divided by Unique Enrollees Served by Collocated.
AVG Service per Enrollee	**Definition**: The average number of collocation services rendered to enrollees who were seen at the PMG during the reporting period. Data entry is not required. **Formula**: Total number of Services rendered divided by Unique Enrollees Served by Collocated.
AVG Service per Hour	**Definition**: The average number of services rendered per hour at the PMG during the reporting period. Data entry is not required. **Formula**: Total number of Services rendered divided by Actual Qtr. Hours of Collocated.
25.B Reverse Collocation	
Facility/Clinic	Enter the name of the clinic or facility written in text.
NPI	Enter the national provider identification number. **Data Format:** Refer to Data Field section associated to NPI field **Rule Validations:** Optional field. If the provider does not have an NPI number, leave this field blank.
Total Enrollees Seen	Enter the total number of unique enrollees seen at the Facility/Clinic for their regular mental health care during the reporting period.
Rev. Co-L Required Hours	Enter the number of quarterly hours required based on the weekly hours required per the type of behavioral health facility as per Attachment 21 of the contract: Guidelines for Reverse Collocation. For facilities that are required to have on-call availability, please use the number of hours available on-call as the parameter and explain in 25.H. **Data Format:** Refer to Data Field Section associated with hours and minutes field
Rev. Co-L Actual Hours	Enter the actual quarterly hours being provided by collocated physical health provider. Any deviation under or over required hours must be explained in 25.H. **Data Format:** Refer to Data Field Section associated with hours and minutes field
Total Patients Seen by Co-L	Enter the total number of all enrollee visits (not unique members) seen due to physical health needs by the collocated physician during the reporting period.

PARAMETER	DEFINITION AND SPECIFICATION
Services Rendered	Enter the total number services rendered by the reversed collocated provider during the reporting period.
Referrals to Physical Health	Enter the total number of referrals to physical health providers, other than visits by the reverse collocated providers during the reporting period.
Enrollees in SMI Registry	Enter the total number of enrollees in the Severe Mental Illness (SMI) Registry served at the facility/clinic, at the end of the reporting period.
SMI seen for Physical Attention	Enter the total number of enrollees enrolled in the SMI registry that were seen by the reverse collocated provider within the reporting period.
Referrals to CM	Enter the number of referrals made for care management by any member of the facility/clinic team during the reporting period.
AVG Patient Per Hour	**Definition:** The average of enrollees who were served at the facility/clinic during the reporting period by actual hours used. Data entry is not required. **Formula:** Total Enrollees Seen divided by Rev. Co-L Actual Hours.
Percent of Enrollees seen by Collocated	**Definition**: The percentage of enrollees seen by a reverse collocated provider at the facility/clinic during the reporting period. Data entry is not required. **Formula**: Total Patients Seen by Co-L divided by Total Enrollees Seen.
Percent of SMI Enrollees Seen	**Definition**: The percentage of enrollees in the SMI registry seen by a reverse co-located provider for physical health reasons. Data entry is not required. **Formula**: SMI seen for Physical Attention divided by Enrollees in SMI Registry.
25.C Enrollee Education Activities	
PMG/Clinic	Enter the name of the clinic or facility written in text.
NPI	Enter the national provider identification number. **Data Format**: Refer to Data Field section associated to NPI fields **Rule Validations:** Optional field. If the facility/clinic does not have an NPI number, leave this field blank.
Enrollees	Enter the total number of enrollees registered with the PMG/facility/clinic (by assignment or selection) as of the last day of the report period.
Enrollees Seen	Enter the total number of unique enrollees seen at the PMG or BH Facility during the reporting period.
Activity Title	Enter the name of the activity/training performed during the reporting period.
Date	Enter the date of the activity/training occurred. **Data Format**: Refer to Data Field section associated to Date fields

PARAMETER	DEFINITION AND SPECIFICATION
Duration	Enter the length of time of the activity/training that took place.
Participants	Enter the number of enrollees who participated in the activity/training.
Participants Percent	**Definition**: The percentage of enrollees who participated in the activity/training at the facility/clinic who are assigned to the entity. Data entry is not required. **Formula**: Participants divided by Enrollees Seen.
25.D Provider Education Activities	
Date	Enter the date of the activity/training. **Data Format**: Refer to Data Field section associated to Date fields
PMG/Facility	Enter the name of the PMG/facility written in text.
NPI	Enter the national provider identification number. **Data Format**: Refer to Data Field section associated to NPI fields **Rule Validations:** Optional field. If the PMG/facility/clinic does not have an NPI number, leave this field blank.
Training Topic	Enter the name of the activity/training performed during the reporting period.
Total Educational Hours	Enter the length of time of the activity/training that took place. **Data Format:** Refer to Data Field Section associated with hours and minutes field
Total PMG/ BH Clinic Staff	Enter the total number of PMG/BH Facility staff members that are currently employed at the end of the reporting period. This number should not include open or unfilled positions.
Count Attending the Activity	Enter the total number of PMG/BH Facility staff members that attended the activity/training being reported.
Attendance Rate	**Definition**: The percentage of clinic staff who participated in the training activity. Data entry is not required. **Formula**: Staff Attending the Activity divided by Total PMG/ BH Clinic Staff.
25.E Care Management	
Section 1 – Care Management Activity	
General	Enrollees will only be counted in one program or initiative as well as in only one condition within initiatives. Enrollees under HC and Special Coverage at the same time will only be counted under HC. For any other duplicate conditions, select the initiative and condition with the most intensive care needs.

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PARAMETER	DEFINITION AND SPECIFICATION
Active Enrollees at the Beginning of the Quarter	Enter the number of enrollees at the beginning of the quarter that are active participants in care management. This applies to enrollees who have not elected to opt out of the program or have had unsuccessful contact attempts. Report enrollees as either Physical Health or Behavioral Health based on their primary diagnosis for care management.
Terminations	Of the active enrollees, enter the number of enrollees who were discharged from care management during the reporting period for any reason other than opt out. Report enrollees as either Physical Health or Behavioral Health based on their primary diagnosis for care management.
New Enrollees	Enter the number of new enrollees contacted during the reporting period that have not opted out of care management. Report enrollees as either Physical Health or Behavioral Health based on their primary diagnosis for care management.
Active Enrollees at the End of the Quarter	Enter the number of enrollees, at the end of the quarter are active participants in care management. This applies to enrollees who have not elected to opt out of the program or have had unsuccessful contact attempts. Report enrollees as either Physical Health or Behavioral Health based on their primary diagnosis for care management.
Candidates with Unsuccessful Contact Attempts	Enter the number of enrollees with at least one unsuccessful contact attempt who are not active or opt out at the end of the quarter, or who have had a contact attempt, but have not been reached at the end of the reporting period. Report enrollees as either Physical Health or Behavioral Health based on their primary diagnosis for care management.
Opt Out Requests	Enter the number of contacted enrollees who elect to opt out of care management during the reporting period. Report enrollees as either Physical Health or Behavioral Health based on their primary diagnosis for care management.
Number of Initial Assessments Performed	Enter the number of initial assessments completed during the report period regardless of enrollees status (active, opt out or terminated). Report enrollees as either Physical Health or Behavioral Health based on their primary diagnosis for care management.
Care Managers	Enter the number of full time care managers not including physicians or administrative staff that are currently employed at the end of the reporting quarter. This number should not include open or unfilled positions. Report care managers as either Physical Health or Behavioral Health based on the distribution of their case load. If mixed enter as Physical Health.

PARAMETER	DEFINITION AND SPECIFICATION
Care Management Support Staff	Enter the number of full time non-clinical supporting staff that is currently employed at the end of the reporting quarter. This number should not include open or unfilled positions. Report care management support staff, as either Physical Health or Behavioral Health based on the distribution of their case load. If mixed enter as Physical Health.
Average Caseload: Care Managers	**Definition**: The average case load for care managers at the end of the quarter. Data entry is not required. **Formula**: Active Enrollees at End of Quarter divided by Care Managers.
Average Caseload: Care Management Support Staff	**Definition**: The average case load for care management support staff at the end of the quarter. Data entry is not required. **Formula**: Active Enrollees at End of Quarter divided by Care Management Support Staff.
Section 2 – Active Enrollees by Program	
Active Enrollees by Program	**Definition**: The total count of active enrollees in care management distributed by program. **Formula**: The sum of active enrollees in care management in the following programs: Special Coverage (without pregnant population) Special Coverage Pregnant Population High Cost (HC) Severe Mental Illness (SMI) ER High Utilizers Chronic Conditions All other An enrollee may only be included in one category. If an enrollee meets the criteria for more than one program, the Contractor shall choose the condition with the most intensive care need.
Section 3 – Active Enrollees by Condition (Select Programs)	
Distribution of Active Enrollees for HC & CC	**Definition**: The total count of active high cost and chronic condition enrollees in care management. Data entry is not required. **Formula**: The sum of active enrollees with High Cost condition and active enrollees with Chronic Conditions. An enrollee may only be included in one category. If an enrollee meets the criteria for more than one condition, the Contractor shall choose the condition with the most intensive care need.

PARAMETER	DEFINITION AND SPECIFICATION
Active Enrollees with High Cost (HC)	**Definition**: The total count of active high cost enrollees in care management distributed by high cost conditions. Data entry is not required. **Formula**: The sum of active enrollees in care management for HC including the following conditions: Cancer ESRD Multiple Sclerosis Rheumatoid Arthritis Children and Youth with Special Health Care Needs Hemophilia Autism An enrollee may only be included in one category. If an enrollee meets the criteria for more than one condition, the Contractor shall choose the condition with the most intensive care need.
Active Enrollees with Chronic Condition (CC)	**Definition**: The total count of active chronic condition enrollees in care management distributed by chronic condition. Data entry is not required. **Formula**: The sum of active enrollees in care management for CC including the following conditions: Diabetes Mellitus Asthma Severe Heart Failure Hypertension COPD Chronic Depression Substance Use Disorders SMI Other than Chronic Depression An enrollee may only be included in one category. If an enrollee meets the criteria for more than one condition, the Contractor shall choose the condition with the most intensive care need.
Section 4 – Screening Activity	
General	This section of the report captures the Contractor's screening activities during the reporting period. Reported screening activities must be reported by program(s): Enrollees in Special Coverage (without pregnant population) Pregnant Women in Special Coverage High Cost Enrollees ER High Utilizers (ERHU) Chronic Conditions Enrollees All Other Enrollees (not applicable to a group above)

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PARAMETER	DEFINITION AND SPECIFICATION
Total Screenings Performed	**Definition:** The total sum of screenings performed by program for the reporting period. Data entry is not required. **Formula:** The sum of screenings performed for each program during the reporting period. If an enrollee meets the criteria for more than one program, the Contractor shall choose the condition with the most intensive care need.
Total Referrals Made	**Definition:** The total sum of referrals made by program for the reporting period. Data entry is not required. **Formula:** The sum of referrals made for each program during the reporting period. If an enrollee meets the criteria for more than one program, the Contractor shall choose the condition with the most intensive care need.
Special Coverage (without pregnant population)	**Definition:** The total sum of screenings performed for Special Coverage (without pregnant population) for the reporting period. Data entry is not required. **Formula:** The sum of the number of the screens performed and entered by the Contractor for enrollees identified in the Special Coverage program as listed: PHQ-9, DAST, M Chat, ASQ/ASQ SE. Other (GAD, PC-PSDT, etc.).
Special Coverage Referred	**Definition:** The total sum of referrals for care management for Special Coverage (without pregnant population) for the reporting period. Data entry is not required. **Formula:** The sum of the number of referrals resulting from the screens performed and entered by the Contractor for enrollees identified in the Special Coverage program as listed: PHQ-9, DAST, M Chat, ASQ/ASQ SE. Other (GAD, PC-PSDT, etc.).
Special Coverage Pregnant Women (PW)	**Definition:** The total sum of screenings performed for Special Coverage Pregnant Women for the reporting period. Data entry is not required. **Formula:** The sum of the number of the screens performed and entered by the Contractor for enrollees identified in the Special Coverage Pregnant Women program as listed: PHQ-9, 4 P Plus, Edinburgh, Other (GAD, PC-PSDT, etc.).
Special Coverage Pregnant Women Referred	**Definition:** The total sum of referrals for care management for Special Coverage Pregnant Women for the reporting period. Data entry is not required. **Formula:** The sum of the number of referrals resulting from the screens performed and entered by the Contractor for enrollees identified in the Special Coverage Pregnant Women program as listed: PHQ-9, 4 P Plus, Edinburgh, Other (GAD, PC-PSDT, etc.).

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PARAMETER	DEFINITION AND SPECIFICATION
High Cost (HC)	**Definition**: The total sum of screenings performed for High Cost (HC) for the reporting period. Data entry is not required. **Formula**: The sum of the number of the screens performed and entered by the Contractor for enrollees identified in the HC program as listed: PHQ-9, DAST, M Chat, ASQ/ASQ SE. Others (GAD, PC-PSDT, etc.).
HC Referred	**Definition**: The total sum of referrals for care management for High Cost enrollees for the reporting period. Data entry is not required. **Formula**: The sum of the number of referrals resulting from the screens performed and entered by the Contractor for enrollees identified in the HC program as listed: PHQ-9, DAST, M Chat, ASQ/ASQ SE. Others (GAD, PC-PSDT, etc.).
ER High Utilizers (ERHU)	**Definition**: The total sum of screenings performed for ER High Utilizers (ERHU) for the reporting period. Data entry is not required. **Formula**: The sum of the number of the screens performed and entered by the Contractor for enrollees identified in the ER High Utilizers (ERHU) program as listed: PHQ-9, DAST, M Chat, ASQ/ASQ SE. Others (GAD, PC-PSDT, etc.).
ERHU Referred	**Definition**: The total sum of referrals for care management for ERHU enrollees for the reporting period. Data entry is not required. **Formula**: The sum of the number of referrals resulting from the screens performed and entered by the Contractor for enrollees identified in the ER High Utilizers (ERHU) program as listed: PHQ-9, DAST, M Chat, ASQ/ASQ SE. Others (GAD, PC-PSDT, etc.).
Chronic Conditions (CC)	**Definition**: The total sum of screenings performed for Chronic Condition (CC) for the reporting period. Data entry is not required. **Formula**: The sum of the number of the screens performed and entered by the Contractor for enrollees identified in the Chronic Conditions program as listed: PHQ-9, DAST, M Chat, ASQ/ASQ SE. Others (GAD, PC-PSDT, etc.).
CC Referrals	**Definition**: The total sum of referrals for care management for Chronic Conditions for the reporting period. Data entry is not required. **Formula**: The sum of the number of referrals resulting from the screens performed and entered by the Contractor for enrollees identified in the Chronic Conditions program as listed: PHQ-9, DAST, M Chat, ASQ/ASQ SE. Others (GAD, PC-PSDT, etc.).

PARAMETER	DEFINITION AND SPECIFICATION
All Other	**Definition**: The total sum of screenings performed for All Other (not identified within a specific program) for the reporting period. Data entry is not required. **Formula**: The sum of the number of the screens performed and entered by the Contractor for enrollees not identified within a specific program therefore categorized as Other as listed: PHQ-9, DAST, M Chat, ASQ/ASQ SE. Others (GAD, PC-PSDT, etc.).
All Other Referrals	**Definition**: The total sum of referrals for care management for All Other (not identified within a specific program) for the reporting period. Data entry is not required. **Formula**: The sum of the number of referrals resulting from the screens performed and entered by the Contractor for members not identified within a specific program therefore categorized as Other as listed: PHQ-9, DAST, M Chat, ASQ/ASQ SE. Others (GAD, PC-PSDT, etc.).
PHQ 9 Screenings	Enter the number of screenings performed for care management using the Patient Health Questionnaire 9 (PHQ 9) during the reporting period for each program category. This screening applies to all program categories.
PHQ 9 Referrals	Enter the number of referrals made for care management resulting from a screening using the Patient Health Questionnaire 9 (PHQ 9) during the reporting period for each program category. This screening applies to all program categories.
DAST Screenings	Enter the number of screenings performed for care management using the Drug Abuse Screen Test (DAST 10) during the reporting period for each applicable program category. This screening applies to all program categories. This screening applies to all program categories except for Special Coverage Pregnant Women (PW).
DAST Referrals	Enter the number of referrals made for care management resulting from a screening using the Drug Abuse Screen Test (DAST 10) during the reporting period for each applicable program category. This screening applies to all program categories except for Special Coverage Pregnant Women (PW).
M CHAT Screenings	Enter the number of screenings performed for care management using the Modified Checklist for Autism in Toddlers (M CHAT) during the reporting period for each applicable program category. This screening applies to all program categories except for Special Coverage Pregnant Women (PW).
M CHAT Referrals	Enter the number of referrals made for care management resulting from a screening using the Modified Checklist for Autism in Toddlers (M CHAT) during the reporting period for each applicable program category. This screening applies to all program categories except for Special Coverage Pregnant Women (PW).
ASQ/ASQ SE Screenings	Enter the number of screenings performed for care management using the Ages and Stages Questionnaire (ASQ) or Ages and Stages Questionnaire Social-Emotional (ASQ-SE) during the reporting period for each applicable program category. This screening applies to all program categories except for Special Coverage Pregnant Women (PW).

PARAMETER	DEFINITION AND SPECIFICATION
ASQ/ASQ SE Referrals	Enter the number of referrals made for care management resulting from a screening using the Ages and Stages Questionnaire (ASQ) or Ages and Stages Questionnaire Social-Emotional (ASQ-SE) during the reporting period for each applicable program category. This screening applies to all program categories except for Special Coverage Pregnant Women (PW).
Other (GAD, PC-PSDT, etc.) Screenings	Enter the number of screenings performed for care management using another type of screen during the reporting period for each program category. This screening applies to all program categories.
Other (GAD, PC-PSDT, etc.) Referrals	Enter the number of referrals made for care management resulting from another type of screen during the reporting period for each applicable program category. This screening applies to all program categories.
4P Plus Screenings	Enter the number of screenings performed for care management using the 4P Plus during the reporting period for the applicable program category. This screening only applies to Special Coverage Pregnant Women (PW).
4P Plus Referrals	Enter the number of referrals made for care management resulting from a screening using the 4P Plus during the reporting period for the applicable program category. This screening only applies to Special Coverage Pregnant Women (PW).
Edinburgh Screenings	Enter the number of screenings performed for care management using the Edinburgh Postnatal Depression Scale (EPDS) during the reporting period for the applicable program category. This screening only applies to Special Coverage Pregnant Women (PW).
Edinburgh Referrals	Enter the number of referrals made for care management resulting from a screening using the Edinburgh Postnatal Depression Scale (EPDS) during the reporting period for the applicable program category. This screening only applies to Special Coverage Pregnant Women (PW).
Section 5 – Cases Seen by Behavioral Health Specialist	
Total Cases seen by Behavioral Health Specialists (From Referrals)	**Definition**: The number of unique enrollees seen by a Behavioral Health Specialists as a result of screening/referral by program: Special Coverage (without pregnant population), Special Coverage Pregnant Population, High Cost (HC), ER High Utilizers, Chronic Conditions or Other. Data entry is not required. **Formula**: The sum of unique enrollees that has been seen within the reporting period as a result of a referral from screening from each program category.
Special Coverage (without pregnant women)	Enter the number of Special Coverage (without pregnant women) unique enrollees that have been seen within the reporting period as a result of a referral from screening.
Pregnant Women	Enter the number of Special Coverage Pregnant Women unique enrollees that has been seen within the reporting period as a result of a referral from screening.
High Cost Utilizers	Enter the number of HC unique enrollees that has been seen within the reporting period as a result of a referral from screening.

PARAMETER	DEFINITION AND SPECIFICATION
ER High Utilizers	Enter the number of ER High Utilizers unique enrollees that has been seen within the reporting period as a result of a referral from screening.
Chronic Conditions	Enter the number of Chronic Condition unique enrollees that has been seen within the reporting period as a result of a referral from screening.
All Other	Enter the number of All Other unique enrollees that has been seen within the reporting period as a result of a referral from screening.
25.F Care Management Pregnant Population/Prenatal & Maternal Program	
Section 1 – Care Management Pregnant Population	
General	This section of the report captures pregnant women enrolled in care management at the end of the reporting period.
Total number of Pregnant Women (includes those enrolled and not enrolled in care management)	Enter the total number of pregnant women, including those enrolled and not enrolled in care management, at the end of the reporting period.
Total number of Pregnant Women Enrolled in Care Management (active and new)	Enter the total number of pregnant women enrolled in care management at the end of the reporting period. This number will differ from the number identified in 25.E as this parameter includes all pregnant enrollees and section 25.E requires the Contractor to prioritize enrollees within the programs listed.
Total number of Births	Enter the total number of births from pregnant women during the reporting period. This includes pregnant women in care management and enrollees not in care management.
Percent of Pregnant Women in Care Management	**Definition**: The percentage of pregnant women in care management as of the last day of the reporting period. Data entry is not required. **Formula**: Total Number of Pregnant Women divided by Total Number of Pregnant Women in Care Management.
New Pregnant Women Identified in the Quarter	**Definition**: The total sum of new pregnant women identified by trimester for care management during the reporting period. Data entry is not required. **Formula**: The sum of new pregnant women identified from the entries by each trimester during the reporting period.
Total Number of Pregnant Women enrolled in their first trimester	Enter the total number of pregnant women who are in their first trimester and are newly identified in the reporting period.

Parameter	Definition and Specification
Total Number of Pregnant Women enrolled in their second trimester	Enter the total number of pregnant women who are in their second trimester and are newly identified in the reporting period.
Total Number of Pregnant Women enrolled in their third trimester	Enter the total number of pregnant women who are in their third trimester and are newly identified in the reporting period.
Distribution by Age of New Identified Pregnant Women	**Definition**: The total sum of new pregnant women identified by age for care management during the reporting period. Data entry is not required. **Formula**: The sum of new pregnant women identified from the entries by age group.
Age <15	Enter the total number of pregnant women who are under the age of 15 years that was newly identified in the reporting period.
Age 15 - 19	Enter the total number of pregnant women who are 15-19 years that was newly identified in the reporting period.
Age 20 - 35	Enter the total number of pregnant women who are 20-35 years that was newly identified in the reporting period.
Age 36 - 40	Enter the total number of pregnant women who are 36-40 years that was newly identified in the reporting period.
Age >40	Enter the total number of pregnant women who are over the age of 40 years that was newly identified in the reporting period.
Section 2 – HIV	
Total number of Pregnant Enrollees who have been Tested for HIV	Enter the total number of pregnant women who received HIV testing at any point during the pregnancy during the reporting period. This is a subset of the total number of pregnant women enrolled (active and new).
Percent of Pregnant Women Tested for HIV	**Definition**: The percent of pregnant women enrolled (active and new) who received HIV testing during their pregnancy. Data entry is not required. **Formula**: Pregnant Women Tested for HIV divided by Pregnant Women Enrolled.
Section 3 – High Risk Pregnant Enrollees	
Total Pregnant Women Identified as High Risk	Enter the total number of pregnant women who have been identified as High Risk by the Contractor at the end of the reporting period.

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PARAMETER	DEFINITION AND SPECIFICATION
New Pregnant Women Identified as High Risk	Enter the total number of pregnant women who have been newly identified as High Risk by the Contractor at the end of the reporting period.
Section 4 – Educational Interventions	
Number of Pregnant Women who Received Educational Interventions	**Definition**: The total sum of pregnant women who received an educational intervention during the reporting period. Data entry is not required. **Formula**: The sum of pregnant women who received an educational intervention by type of intervention.
Written	Enter the total number of pregnant women who received some form of written educational intervention during the reporting period.
Phone	Enter the total number of pregnant women who received some form of phoned educational intervention during the reporting period.
Face to Face	Enter the total number of pregnant women who received some form of face to face educational intervention during the reporting period.
Section 5 – Prenatal and Maternal Program	
Total Pregnant Women Served Through P/M During the Quarter	Enter the total number of pregnant enrollees who received any type of service through the Prenatal and Maternal program during the reporting period. This parameter is a count of unique members and not a count of the services rendered.
Percent	**Definition**: The percent of pregnant women enrolled (active and new) who received services related to the prenatal and maternal program during the reporting period. Data entry is not required. **Formula**: The total number of pregnant women who received services through the prenatal and maternal program divided by the total number of pregnant women.
Section 6 – Services Rendered	
Counseling regarding HIV testing	Enter the number of pregnant women who were offered and received counseling regarding HIV testing during the reporting period.
Pregnancy testing	Enter the number of pregnant women who were offered and received pregnancy testing during the reporting period.
RhoGAM Injection	Enter the number of pregnant women who have a negative Rhesus ("Rh") factor and were offered and received the RhoGAM injection according to the established protocol during the reporting period.

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PARAMETER	DEFINITION AND SPECIFICATION
Screenings (4P Plus, Edinburgh or other)	Enter the number of pregnant women who were offered and received Screenings (4P Plus, Edinburgh or other) during the reporting period.
Smoking Cessation Counseling and Treatment	Enter the number of pregnant women who were offered and received Smoking cessation counseling and treatment during the reporting period.
Post-partum Counseling and Referral to the WIC Program	Enter the number of pregnant women who were offered and received Post-partum counseling and Referral to the WIC program during the reporting period.
Dental Evaluation during the Second Trimester of Gestation	Enter the number of pregnant women who were offered and received Dental evaluation during the second trimester of gestation during the reporting period.
Educational Workshops (specify in 25.H)	Enter the number of pregnant women who were offered and received Educational workshops (specify in 25.H) during the reporting period.
Other (specify in 25.H)	Enter the number of pregnant women who were offered and received Other counseling (specify in 25.H) during the reporting period. Include any other services not captured above that the Contractor would like to include and that will be described in the notes section.
Section 7 – Educational Workshops	
Topic	List by topic, all educational workshops rendered to pregnant women during the reporting period.
25.G Smoking Cessation, Autism, ADD, Buprenorphine	
Section 1 – Smoking Cessation	
Smoking Cessation	Smoking Cessation Registered Enrollees are active participants in the smoking cessation program (SCP) who have accepted participation.
Total Patients Registered in the SCP at the End of the Quarter	Enter the total number of enrollees registered in a SCP at the end of the reporting period.
Enrollees Served by Intervention	**Definition**: The total number of enrollees served by an intervention (counseling, medication treatment, education or other) in the SCIP at the end of the reporting period. Data entry is not required. **Formula**: The sum of the interventions entered as counseling, medication treatment, education or other at the end of the reporting period.

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PARAMETER	DEFINITION AND SPECIFICATION
Counseling	Enter the total number of enrollees registered in the SCP that received counseling during the reporting period.
Medication Treatment	Enter the total number of enrollees registered in the SCP that received medication treatment during the reporting period.
Education	Enter the total number of enrollees registered in the SCP that received education during the reporting period.
Other (Specify in 25.H)	Enter the total number of enrollees registered in the SCP that received other services during the reporting period.
Section 2 – Autism Spectrum Disorder	
Registered Patients (including New Patients)	**Definition**: The total number of enrollees diagnosed with an Autism Spectrum Disorder at the end of the reporting period. Data entry is not required. **Formula**: The sum of female and male enrollees diagnosed with an Autism Spectrum Disorder at the end of the reporting period.
Female	Enter the total number of female enrollees diagnosed with an Autism Spectrum Disorder at the end of the reporting period.
Male	Enter the total number of male enrollees diagnosed with an Autism Spectrum Disorder at the end of the reporting period.
New Patients in the Reporting Quarter	Enter the total number of new enrollees diagnosed with an Autism Spectrum Disorder at the end of the reporting period.
Registered Patients <21 years	Enter the total number of enrollees under the age of 21 years diagnosed with an Autism Spectrum Disorder at the end of the reporting period.
Registered Patients ≥21 years	Enter the total number of enrollees aged 21 years or over diagnosed with an Autism Spectrum Disorder at the end of the reporting period.
Amount of Services Rendered (Related to the Condition)	**Definition**: The total amount of services rendered to enrollees diagnosed with an Autism Spectrum Disorder during the reporting period. Data entry is not required. **Formula**: The sum of the services rendered to enrollees diagnosed with an Autism Spectrum Disorder received during the reporting period.
Physical Health Services	Enter the total number of physical health services enrollees diagnosed with an Autism Spectrum Disorder received during the reporting period.
Behavioral Health Services	Enter the total number of behavioral health services enrollees diagnosed with an Autism Spectrum Disorder received during the reporting period.

PARAMETER	DEFINITION AND SPECIFICATION
Section 3 – ADD/ADHD	
Number of Registered Patients (Including New Members)	**Definition**: The total number of enrollees diagnosed with an Attention Deficient Disorder (ADD) or Attention Deficient Hyperactivity Disorder (ADHD) at the end of the reporting period. Data entry is not required. **Formula**: The sum of female and male enrollees diagnosed with an ADD/ADHD at the end of the reporting period.
Female	Enter the total number of female enrollees diagnosed with an ADD/ADHD at the end of the reporting period.
Male	Enter the total number of male enrollees diagnosed with an ADD/ADHD at the end of the reporting period.
New Patients in the Reporting Quarter	Enter the total number of new enrollees diagnosed with ADD/ADHD during the reporting period.
Amount of Condition Related Services Provided	**Definition**: The total number of services rendered to enrollees with ADD/ADHD during the reporting period. Data entry is not required. **Formula**: The sum of the services rendered to enrollees diagnosed ADD/ADHD during the reporting period.
Pharmacy (psychostimulants)	Enter the total number of pharmacy related services (prescriptions) enrollees diagnosed with ADD/ADHD received during the reporting period. Note this relates only to medications for ADD/ADHD.
Physical Specialist Services	Enter the total number of physical health services enrollees diagnosed with ADD/ADHD received during the reporting period.
Behavioral Services	Enter the total number of behavioral health services enrollees diagnosed with ADD/ADHD received during the reporting period.
Section 4 – Buprenorphine Program	
Number of Patients under Treatment (including new patients in the quarter)	Enter the total number of enrollees receiving Buprenorphine treatment by the end of the reporting period. This includes new patients from line below.
New Patients in the Reporting Quarter	Enter the total number of enrollees who began receiving Buprenorphine treatment during the reporting period.
Demographic Data of Active Patients	**Definition**: The total number of enrollees receiving Buprenorphine treatment at the end of the reporting period. Data entry is not required. **Formula**: The sum of male and female enrollees by age categories.

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PARAMETER	DEFINITION AND SPECIFICATION
Female by Age Category	**Definition**: The total number of female enrollees receiving Buprenorphine treatment at the end of the reporting period. Data entry is not required. **Formula**: The sum of female enrollees by age categories.
Male by Age Category	**Definition**: The total number of male enrollees receiving Buprenorphine treatment at the end of the reporting period. Data entry is not required. **Formula**: The sum of male enrollees by age categories.
18 - 29	Enter the number of female or male enrollees receiving Buprenorphine treatment between the ages of 18-29 years by the end of the reporting period.
30 - 41	Enter the number of female or male enrollees receiving Buprenorphine treatment between the ages of 30-41 years by the end of the reporting period.
42 - 53	Enter the number of female or male enrollees receiving Buprenorphine treatment between the ages of 42-53 years by the end of the reporting period.
54 - 64	Enter the number of female or male enrollees receiving Buprenorphine treatment between the ages of 54-63 years by the end of the reporting period.
65 or over	Enter the number of female or male enrollees receiving Buprenorphine treatment 65 years or over by the end of the reporting quarter.
Total Active Patients	**Definition**: The total number of enrollees active in receiving Buprenorphine treatment at the end of the reporting period. Data entry is not required. **Formula**: The sum of active patients by timeframes (less than 3 months, 3-6 months, 7-12 months or over 1 year).
Active Patients less than 3 months	Enter the total number of enrollees receiving Buprenorphine treatment who have been in active treatment less than 3 months.
Active Patients from 3 to 6 months	Enter the total number of enrollees receiving Buprenorphine treatment who have been in active treatment between 3-6 months.
Active Patients from 7 to12 months	Enter the total number of enrollees receiving Buprenorphine treatment who have been in active treatment between 7-12 months.
Active Patients over 1 year	Enter the total number of enrollees receiving Buprenorphine treatment who have been in active treatment over 12 months.
Termination of Treatment	**Definition**: The total number of enrollees who were terminated from Buprenorphine treatment at the end of the reporting period. Data entry is not required. **Formula**: The sum of the number of enrollees terminated from Buprenorphine treatment by the entries for the reason of termination.

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PARAMETER	DEFINITION AND SPECIFICATION
Noncompliance with treatment plan	Enter the number of enrollees terminated from Buprenorphine treatment due to non-compliance with the treatment plan during the reporting period.
Intolerance of treatment	Enter the number of enrollees terminated from Buprenorphine treatment due to intolerance of treatment during the reporting period.
Abandonment of Treatment	Enter the number of enrollees terminated from Buprenorphine treatment due to abandonment of treatment during the reporting period.
Contraindications	Enter the number of enrollees terminated from Buprenorphine treatment due to contraindications during the reporting period.
Other reasons	Enter the number of enrollees terminated from Buprenorphine treatment due to any other reason during the reporting period.
Employed/Student	Enter the number of unique enrollees who are a part time or full time student or are employed part time or full time receiving Buprenorphine treatment as of the last day of the reporting period.
Stability in Housing	Enter the number of unique enrollees who have a stable living arrangement receiving Buprenorphine treatment as of the last day of the reporting period.
25.H Notes	
Notes	In no prescribed format, describe pertinent information to the report, including analysis and explanations of any abnormalities within the reported data or reasons for unusual increases or decreases, as applicable.

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Report 27 – Business Continuity and Disaster (BCDR) Report

Citrix Share link location:

CITRIX SHARE LOCATION
Systems > 5-Annually

Purpose:

The Business Continuity and Disaster Recovery ("BC-DR") Test Report captures annual tests of the BC-DR system and report the findings of the test results with the system generated log report.

Submission Requirement:

The report is due on an annual basis within 90 days after the end of the Plan Vital contract year and monitors the requirements of 18.2 of the contract. The results of these tests shall be reported to ASES within thirty (30) Calendar Days of completion of said tests.

Parameters: All fields are required if no other specific instructions are detailed for each field.

There is no prescribed format.

PARAMETER	DEFINITION AND SPECIFICATION
27.A Business Continuity and Disaster Recovery Test Report	
General	On an annual basis, the Contactor must test the BC-DR plan through simulated disasters and lower level failures in order to demonstrate to ASES that it can restore System functions per the standards outlined 17.5 of the Contract. The results of these tests shall be reported to ASES within thirty (30) Calendar Days of completion of said tests.
System Tested	Identify the system tested; list each system on a separate line. Testing may include but is not limited to: Enrollee and Provider portal and/or phone-based functions and information Confirmation of Contractor Enrollment (CCE) Electronic Claims Management (ECM)
Tests Completed	Enter a description of each system tested and the nature of the completed tests.
Date Test Completed	Enter the date the test was completed. **Data Format**: Refer to Data Field section associated to Date fields
Test Result	Enter a description of the test result.
Automated Methods	Enter a description of automated methods used to monitor critical systems based on required timeframes.
Contract Compliance	Indicate Yes or No, if the system is in compliance with contractual requirements as applicable. **Rule Validations:** Optional field. If not applicable, leave this field blank.

PARAMETER	DEFINITION AND SPECIFICATION
Expected Improvements	For each system, enter a description of any expected improvements or changes to the system.

Report 28 – Unaudited Financial Statement

Citrix Share link location:

CITRIX SHARE LOCATION
Finance > 3-Quarterly

Purpose:

The Unaudited Financial Statement Report monitors the Contractor's financial operations.

Submission Requirement:

The report is due on a quarterly basis and monitors the requirements of 18.2 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

Generally accepted accounting principles are to be observed in the preparation of these reports. All revenues and expenses must be reported using the full accrual basis method of accounting.

Many line and column descriptions within each report are self-explanatory and do not necessitate instructions. However, specific instructions are provided in instances when interpretation may vary. Any entry for which no specific instruction is provided should be made in accordance with sound accounting principles and in a manner consistent with related items for which instruction is provided.

For quarterly amounts prior to the reporting period, amounts should agree to those submitted to ASES in the relevant prior quarter(s). If any adjustments are necessary, provide explanation to ASES.

Always use predefined categories or classifications before reporting an amount as "Other." For any material amount included as "Other", the Contractor is required to provide a detailed explanation as directed.

PARAMETER	DEFINITION AND SPECIFICATION
28.A Balance Sheet	
Cash and Equivalents	Enter the cash and cash equivalents available for current use. Cash equivalents are investments maturing 90 days or less from the date of purchase.
Reinsurance Receivable	Enter the accrued reinsurance receivable amounts due to contractual agreements with reinsurance contractors.
Due from Affiliates	Enter the receivables from related party organizations.
Premiums Receivable	Enter the premium payments earned, but not yet received from ASES.
Other Accounts Receivable	Enter the amounts receivable not accounted for elsewhere on the balance sheet. Any receivables from providers due to overpayments should be accounted for in this line item.
Prepaid Expenses	Enter the expenses paid in advance, excluding income taxes.

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PARAMETER	DEFINITION AND SPECIFICATION
Prepaid Income Taxes	Enter the income taxes paid in advance or income taxes receivable.
Other Assets	Enter any other assets not accounted for elsewhere on the balance sheet, including but not limited to property and equipment, long-term investments, performance bonds, etc.
Claims Payable	Claims payable consists of estimates of incurred claims less paid claims for current and prior periods. The following two lines below are included in the calculation.
Incurred Related to Current/Prior Period	Enter the amount of claims payable, including IBNR, segregated for the reporting period (current period) and all other periods (prior period).
Paid Related to Current/Prior Period	Enter the amounts of claims paid, segregated for the reporting period (current period) and all other periods (prior period), entered as a negative amount. These amounts should be included as part of the totals in lines 11 and 12 (as positive amounts).
Accrued Medical Incentive Pool and Bonus Amounts	Enter the payables for incentive or bonus payment arrangements with providers.
General Expenses Due or Accrued	Enter the amounts due to creditors for the acquisition of goods and services on a credit basis, other accrued expenses, management fees, and any other amounts estimated as of the balance sheet date (e.g., payroll, taxes). Also, include accrued interest payable on debts.
Income Tax Payable	Enter the income and related taxes payable as of the balance sheet date.
Due to Affiliates	Enter the amounts due to related party organizations.
Validation	Ensure the validation line proves that the total assets on line 10 equal total liabilities and surplus on line 30.
28.B Income Statement	
Member Months	Enter the member months for the reporting quarter for which the Contractor has received and/or accrued premium revenue.
Earned Premiums	Enter the premiums received and accrued on a prepaid basis for the provision of covered services.
Other Income	Enter all other revenue or income received and accrued excluding premium revenue reported in line 3.
Line 10 - Inpatient Hospital Services through Line 15 – Other Medical Services	See detail on the "C – Total Profitability" section for detailed categories of service to be included within each of these line items. The subtotals for each category from the Total Profitability tab should agree to what is reported on lines 10 through 15 of the Income Statement.

PARAMETER	DEFINITION AND SPECIFICATION
Capitation Payments	Enter the amount paid and accrued to providers under capitated arrangements.
Incentive Pool, Withhold Adjustments and Bonus Amounts	Enter the amount paid and accrued to providers with which the Contractor has incentive, withhold and/or bonus arrangements.
Reinsurance Premiums	Enter the amount paid and accrued for reinsurance stop-loss coverage with contracted entities. Do not include reinsurance recoveries on this line.
Reinsurance Recoveries	Enter the amount received and accrued for recoveries under reinsurance arrangements. Enter as a negative amount. Do not include the cost of reinsurance premiums on this line.
Post Payment Recoveries	Enter the cost recoveries subsequent to the payment of a claim that has not been adjusted in the original claim, including recoveries associated with third party resources, fraud and abuse and any other recovery efforts.
Income Taxes	Enter the Income tax expense paid and/or accrued for the period.
Accumulated Surplus – Beginning of Period	For the first reporting period only, enter the ending accumulated surplus amount from the prior reporting period.
28.B1 Administrative Detail	
Health Care Quality Improvement (HCQI)	Amounts reported on lines 1 through 11 should adhere to HCQI activities as defined in 45 CFR § 150.158. To qualify as HCQI, the activity must: • Improve health quality. • Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. • Be directed toward Medicaid enrollees or incurred for the benefit of Medicaid enrollees or provide health improvements to the population beyond Medicaid as no additional costs due to the non-Medicaid enrollees. • Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations. • The Contractor should report all health care quality improvement expenses using the categories presented in lines 1 through 11. Expenses reported on line 11, Other HCQI*, must be fully detailed on Schedule B1.2 – Other Administrative Costs. All HCQI expenses should only include expenses associated with the administration of the Medicaid program.

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PARAMETER	DEFINITION AND SPECIFICATION
Other Administrative Costs	Enter the amounts for self-explanatory line items shown on lines 13 through 28. The amount reported on line 22, Other Direct Costs*, must be fully detailed on Schedule B1.1, Other Direct Costs. The total reported on Schedule B1.1 must agree to the amount reported on line 22 of this schedule. For line 28, Other Administrative Costs, report amounts not relevant to any other categories presented elsewhere. The amount reported on line 28, Other Administrative Costs*, must be fully detailed on Schedule B1.2, Other Administrative Costs. The total reported on Schedule B1.2 for these costs must agree to the amount reported on line 28 of this schedule.
Unallowable Service Expenses	Report amounts for self-explanatory line items shown on lines 31 through 41. Note contract references for guidance as needed.
28.B1.1 Other Direct Costs	
Other Direct Costs	Report the details of line 22 from Schedule B1 – Administration Detail. Detail amounts must agree to the amount reported on Schedule B1, line 22.
Validation	Ensure the validation line proves that the reported amount agrees to line 22 of Schedule B1.
28.B1.2 Other Administrative Costs	
Other Administrative Costs	Report the details of lines 11 and 28 from Schedule B1 – Administration Detail. Detail amounts must agree to the amounts reported on Schedule B1, lines 11 and 28.
Validation	Ensure the validation line proves that the reported amount agrees to the total of lines 11 and 28 of Schedule B1.
28.C Total Profitability	
Incurred Claims by Service Category	Lines 2 through 42, enter all incurred and paid claims expenses by categories of service, consistent with reporting from B-Income Statement. Use 'Miscellaneous' and 'Other' line items only if the expense does not fit into other line items provided elsewhere. Do not include IBNR or accrual amounts in lines 2 through 42.
IBNR	Enter amounts estimated for incurred but not reported (IBNR) claims for services rendered.
Accrued Capitation Amount	Enter amounts due to providers under capitated arrangements as of the reporting date.
Accrued Incentive Pool, Withhold Adjustments and Bonus	Enter amounts accrued to providers with which the Contractor has incentive, withhold and/or bonus arrangements.

PARAMETER	DEFINITION AND SPECIFICATION
Other Accrued General Medical Expenses	Enter amounts estimated for claims received but unpaid as of the reporting date and any other accruals for covered services not included in lines 44 through 46.
Validation	Ensure the validation line proves that the reported amount agrees to the total of lines 11 and 28 of Schedule B1.
28. D MLR Calculation	
MLR Calculation Section	The purpose of this report is to provide the Contractor and ASES with YTD MLR monitoring information. It is not intended to produce any official rebate amounts due to ASES.
Premium Tax Component of Reported Revenue	Enter the amount of premium tax included in YTD Premiums as reported in Earned Premiums, line 2 of Schedule B, Income Statement. Report the YTD amount.
HIPF	Enter the amount of health insurance provider fee included YTD Premiums as reported in Earned Premiums, line 2 of Schedule B, Income Statement. Report the YTD amount.
Incurred Claims Adjustments	Lines 7 through 10, report any additions, deductions, exclusions or adjustments to YTD Net Medical Expenses are reported on line 18, Total Medical Expenses. Report amounts as positive or negative as instructed on each line item. Adjustments must be reported as defined in 42 CFR 438.8 (e)(2).
Adjustments or Exclusions to HCQI/HIT Meaningful Use Expenses	Report adjustments to HCQI amounts reported on Schedule B1 – Administration Detail, line 12, as defined in 42 CFR 438.8 (e)(3). Enter as negative amount if reporting an exclusion.
Lesser of Fraud Reduction Expenses or Fraud Recoveries	Enter the amount of fraud reduction (not fraud prevention) expenses up to the amount of fraud recoveries. The amount reported should not exceed the amount of fraud related recoveries. See 42 CFR 438.8 (e)(4) for guidance as needed.
28.D1 Credibility Adjustment Calculation	
MLR Credibility Adjustment	No input necessary on this section. Other entries within the report will calculate a credibility adjustment as appropriate based on guidance at the following: https://www.medicaid.gov/federal-policy-guidance/downloads/cib073117.pdf.
28.D2 MLR Report Summary	
MLR Report Summary	No input necessary on this tab. The summary information presented is for ASES use only.

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Report 29 – Report on Controls Placed in Operations and Tests of Operating Effectiveness (SSA E 18)

Citrix Share link location:

CITRIX SHARE LOCATION
Finance > 5-Annually

Purpose:

The Report on Controls Placed in Operations and Tests of Operating Effectiveness monitors requirements of the AICPA's SSAE 18 for the Contractor's operations performed for ASES under this Contract.

Submission Requirement:

The report is due on an annual basis within 90 days after the end of the Plan Vital contract year. and monitors the requirements of 18.2 and 23.7 of the contract.

Parameters:

No specified format.

PARAMETER	DEFINITION AND SPECIFICATION
29.A Report on Controls Placed in Operations and Tests of Operating Effectiveness	
General	The Contractor, at its sole expense, shall submit by May 15 (or a later date if approved by ASES) of each year a "Report on Controls Placed in Operation and Tests of Operating Effectiveness," meeting all standards and requirements of the SSAE 18 for the Contractor's operations performed for ASES under the GHP Contract.
Audit	The audit shall be conducted by an independent auditing firm, with prior audit experience using AICPA "Statements on Auditing Standards". The auditor shall meet all AICPA standards for independence. The selection of, and contract with the independent auditor shall be subject to the prior written approval of ASES. ASES reserves the right to, at the Contractor's expense; designate other auditors or reviewers to examine the Contractor's operations and records for monitoring and/or stewardship purposes.
Audit Delivery	The Contractor will deliver to ASES, along with the Report on Controls Placed in Operation and Tests of Operating Effectiveness, the findings and recommendations of the independent audit firm encountered in the preparation of such a report. The audit shall be conducted and the report shall be prepared in accordance with generally accepted auditing standards for such audits as defined in the publications of the AICPA, entitled "Statements on Auditing Standards" (SAS). In particular, SSAE 18 is to be used.

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PARAMETER	DEFINITION AND SPECIFICATION
Findings	The Contractor shall respond to the audit findings and recommendations within thirty (30) Calendar Days of receipt of the final audit report. The Contractor must submit a Corrective Action Plan to ASES which will be subject to ASES' prior review and written approval within twenty (20) Calendars Days of the notification of the audit. The Contractor must implement the Corrective Action Plan, as a maximum, within fifteen (15) Calendar Days of its approval by ASES.

Report 30 – Audited Financial Statements

Citrix Share link location:

CITRIX SHARE LOCATION
Finance > 5-Annually

Purpose:

The Audited Financial Statements Report captures audited financial statements following general accepted accounting principles and generally accepted auditing standards, regarding the financial operations related to the GHP Program.

Submission Requirement:

The report is due on an annual basis within 90 days after the closing of the Contractor's fiscal year, and monitors the requirements of 18.2 and 23.1 of the contract.

Parameters:

No format specified.

Report 31 – Cost Avoidance Report

Citrix Share link location:

Citrix Share Location
Finance > 3-Quarterly

Purpose:

The Cost Avoidance Report monitors third party liability activity occurring on claims incurred for enrollees.

Submission Requirement:

The report is due on a quarterly basis and monitors the requirements of 18.2 of the contract.

Parameters:

Parameter	Definition and Specification
31.A COB Detail	
Municipality Code	Enter the municipality code of the enrollee. Refer to the list of municipality codes of the Carrier to ASES Data Submissions-New File Layouts-Version 4.0B. **Rule Validations:** Required.
Claim Reference #	Enter the claim reference number as assigned and included in the monthly claims file submitted by the Contractor. Note: If the claim is not included in the monthly claims file (Report 12) submitted for the corresponding period, the report will be considered in error and returned to the MCO.
Member Type	Select the member type of the enrollee for the specific claim based on the codes descriptions and codes shown on the associated XSD.
TPL Type	Indicate the third party liability type of additional insurance held by the enrollee for the specific claim, based on the codes and descriptions shown on the XSD.
Amount Paid	Enter the amount paid by the third party toward the specific claim.
Appendix – Member and TPL Type	
Member Type and Code/TPL Type and Code	Provides enrollee and TPL codes for use in reporting the above section (COB detail). No data entry required.

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Report 32 – Report to Puerto Rico Insurance Commissioner's Office

Citrix Share link location:

CITRIX SHARE LOCATION
Finance > 5-Annually

Purpose:

The Contractor must submit an annual Report to Puerto Rico Insurance Commissioner's Office in the format agreed upon by the National Association of Insurance Commissioners (NAIC).

Submission Requirement:

The report is due on an annual basis and is due each year on March 31, and monitors the requirements of 18.2 of the contract.

Parameters:

No parameters or format specified.

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Report 33 – Annual Corporate Report

Citrix Share link location:

CITRIX SHARE LOCATION
Finance > 5-Annually

Purpose:

The Contractor must provide to ASES a copy of the annual corporate report of its parent company at the close of the calendar year.

Submission Requirement:

The report is due on an annual basis within 90 days after the closing of the Contractor's fiscal year, and monitors the requirements of 18.2 of the contract.

Parameters:

No specified parameters or format.

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Report 34 – Pharmacy Certification

Citrix Share link location:

CITRIX SHARE LOCATION
Finance > 1.5- Bi-Weekly

Purpose:

The Contractor must submit a duly signed Pharmacy Certification every two weeks, including the amount of pharmacy claims paid, rejected, denied, reversed and adjusted. This report is used to document the MCO's certification that the listing of medications dispatched and paid bi-weekly to confirm the administrative payment to the PBM.

Submission Requirement:

The report is due every two weeks within the following two days of MC21 cut-off period and monitors the requirements of 18.2 of the contract and should reflect the previous two weeks of the period.

Parameters: All fields are required if no other specific instructions are detailed for each field.

PARAMETER	DEFINITION AND SPECIFICATION
34.A Pharmacy Certification	
Paid Claims	Enter the number of pharmacy claims adjudicated during the reporting period to a paid status.
Rejected Claims	Enter the number of pharmacy claims adjudicated during the reporting period to a rejected status.
Denied Claims	Enter the number of pharmacy claims adjudicated during the reporting period to a denied status.
Reversed Claims	Enter the number of pharmacy claims adjudicated during the reporting period where the status was reversed.
Adjustments	Enter the number of claims with adjustments adjudicated during the reporting period.
Total Claims	The total number of pharmacy claims adjudicated during the reporting period. Data entry is not required. **Formula:** The sum count of paid, rejected, denied, reversed claims and adjustments at the end of the reporting period.

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Report 35 – IBNR

Citrix Share link location:

CITRIX SHARE LOCATION
Finance > 3-Quarterly

Purpose:

The report monitors IBNR activities on a quarterly basis.

Submission Requirement:

The report is due on a quarterly basis and monitors the requirements of 18.2.9.8 of the contract.

Parameters: All fields are required if no other specific instructions are detailed for each field.

With each quarterly submission, the Contractor must submit supporting information in PDF form related to the development and accuracy of historical medical claims liability estimates. These schedules provide the necessary information to make this analysis. Prepare the schedule segregated by medical, dental and pharmacy experience as indicated by the each section name and report title.

Service costs must be reported net of coordinated benefits or third-party liability (COB/TPL). Claims liabilities should not include the administrative portion of claim settlement expenses. Any liability for future claim settlement expenses must be disclosed separately in a footnote from the unpaid claim liability.

For each Period (End Period), the payments corresponding to the quarter (end period) must be reported, based on the months in which the service was provided.

PARAMETER	DEFINITION AND SPECIFICATION
35.A/35.B/35.C Lag & IBNR	
Month of Payment	Only payments made during the current reporting quarter should be reported in the corresponding section for each date of service by type of service: medical, dental and pharmacy. The current month is the last month of the period that is being reported.
Month in Which Service Provided	Payments made relating to the appropriate month of payments.
Global/Subcapitation Payments	Global/subcapitation payments only should be reported by month of service.
Incentive pool, withhold adjustments and bonus amounts	Incentive pool, withhold adjustments and provider bonus payments made from the Contractor to providers should be reported by month of service. Include other payment(s) for medical expenses not paid through the claims system.

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PARAMETER	DEFINITION AND SPECIFICATION
Settlements	Report payments/recoupment in the corresponding section for payments to the extent possible. If the Contractor makes a settlement or other payment that cannot be reported in the payment section due to lack of data or the inability to adjust a claim in the Contractor claims processing system, the amount must be reported in the appropriate service month. If the settlement reflects receipts for more than one service month, allocate the settlement evenly between the appropriate service months. The Contractor may use an alternative method of reporting settlements that restates prior period amounts to reflect an actual settlement for that month. Do not include adjustments to IBNR amounts in this column. Settlements should include payments to or refunds from providers that cannot be linked to a specific claim adjudicated through the payment system. For instance, fraud abuse recoupments and inaccurate payment settlement agreements with a provider that have not been captured through the claims payment system should be included.
Current estimate of claims incurred but not paid (IBNR), exclusive of an explicit margin for adverse deviation	Amounts on this column represent the current estimates for unpaid claims by month of service for the past 36 months, and the aggregate amount for all prior months. The Contractor must determine a new IBNR amount for each service month and include this amount on this column. The development of each IBNR should be based on the most recent paid claims data. The remaining estimate of IBNR includes services incurred for which Contractor has not yet received the claim; claims the Contractor has received, but have not yet processed; and claims the Contractor has received and processed, but for which the Contractor has not mailed the check. Do not include estimates of explicit margin for adverse deviation.
Explicit margin for adverse deviation on IBNR	Report the estimated explicit margin for adverse deviation in relation to IBNR reported.

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Appendix 1 – Summary of Reports Submission Formats

REPORT NUMBER	REPORT TITLE	FORMAT
01	Call Center Report	**XML**
02	Enrollee Enrollment Materials Report	**XML**
03	Fraud Waste Abuse Report	**XML**
04	Privacy and Confidentiality Report (Data Breach)	**XML**
05	System Incident & Availability Report	**XML**
06	Federally Qualified Health Center Report (FQHC 330)	**XML**
07	Special Coverage Registry Report	**XML**
08	High Cost High Need Registry	**XML**
09	Disclosure of Information on Annual Business Transactions	**XML**
10	Annual Statistical Report	**XML**
11	Claims Activity Report	**XML**
12	Encounter Data (Electronic Data File)	**CLM**
13	CMS-416 Report - EPSDT	**XLS**
14	Executive Director and Utilization Data Report	**XML**
15	Network Provider List Report	**XML**
16	Geographic Access Report	**XML**
17	Appointment Availability Report	**XML**
18	Provider Satisfaction Survey Report	**PDF**
19	Provider Training and Outreach Evaluation Report	**XML**
20	Physician Incentive Report	**XML**
21	Grievances and Appeals Report	**XML**

Report Number	Report Title	Format
22	Health Care Improvement Program	XML
23	Enrollee Satisfaction Survey Report	PDF
24	Audited HEDIS Results Report	XML
25	Utilization Management and Integration Model	XML
27	Business Continuity and Disaster Recovery (BC-DR) Test Report	XML
28	Unaudited Financial Statement	XML
29	Report on Controls Placed in Operation and Tests of Operating Effectiveness (SSA E 16)	PDF
30	Audited Financial Statements	PDF
31	Cost Avoidance Report	XML
32	Report to Puerto Rico Insurance Commissioner's Office	PDF
33	Annual Corporate Report	PDF
34	Pharmacy Certification	PDF
35	Incurred But Not Paid Report (IBNR)	XML

Appendix 1.1 XML Reports

Report Number	Short Name	How many files Expected?	Formats
1	CALLCENT	2	1 XML 1 PDF
2	ENRMAT	2	1 XML 1 PDF
3	FWA	2	1 XML 1 PDF
4	PRIVCONF	2	1 XML 1 PDF
5	SYSTAVA	2	1 XML 1 PDF
6	FQHC(330)	2	1 XML 1 PDF
7	SPECOV	2	1 XML

Report Number	Short Name	How many files Expected?	Formats
			1 PDF
8	HCHN	2	1 XML 1 PDF
9	DISABT	2	1 XML 1 PDF
10	STATREP	2	1 XML 1 PDF
11	CLMACT	2	1 XML 1 PDF
14	EXECDIR	2	1 XML 1 PDF
15	NPL	2	1 XML 1 PDF
16	GEO	2	1 XML 1 PDF
17	APPAV	2	1 XML 1 PDF
19	PROVTO	2	1 XML 1 PDF
20	PHYINC	2	1 XML 1 PDF
21	G&A	2	1 XML 1 PDF
22	HCIP	2	1 XML 1 PDF
24	HEDIS	2	1 XML 1 PDF
25	UMINT	2	1 XML 1 PDF
27	BCDR	2	1 XML 1 PDF
28	QTRFINSTA	2	1 XML 1 PDF
31	COB	2	1 XML 1 PDF
35	IBNR	2	1 XML 1 PDF

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Appendix 1.2 PDF reports:

Report Number	Report Title	How many files Expected?	Formats
18	PROVSS	1	PDF
23	ENRSS	1	PDF
29	CONTTEST	1	PDF
30	AUDFINST	1	PDF
32	ICANNSTA	1	PDF
33	CORP	1	PDF
34	PHACER	1	PDF

Appendix 2 – Report Short Names and Frequency

PVCY= Plan Vital Contact Year, PRFY= PR Fiscal Year, FFY= Federal Fiscal Year, CY= Calendar Year

#	Report Title	Short Name	Frequency
01	Call Center Report	CALLCENT	Monthly
02	Enrollee Enrollment Materials Report	ENRMAT	Quarterly
03	Fraud Waste Abuse Report	FWA	Quarterly
04	Privacy and Confidentiality Report (Data Breach)	PRIVCONF	Monthly
05	System Incident & Availability Report	SYSTAVA	Monthly
06	Federally Qualified Health Center Report (FQHC 330)	FQHC 330	Quarterly
07	Special Coverage Registry Report	SPECOV	Monthly
08	High Cost High Need Registry	HCHN	Monthly
09	Disclosure of Information on Annual Business Transactions	DISABT	Annual - PVCY
10	Annual Statistical Report	STATREP	Annual - PRFY
11	Claims Activity Report	CLMACT	Monthly
12	Encounter Data (Electronic Data File)		Monthly
13	CMS-416 Report - EPSDT	EPSDT 416	Annual - FFY
14	Executive Director and Utilization Data Report	EXECDIR	Quarterly
15	Network Provider List Report	NPL	Monthly
16	Geographic Access Report	GEO	Quarterly
17	Appointment Availability Report	APPAV	Quarterly
18	Provider Satisfaction Survey Report	PROVSS	Annual - CY
19	Provider Training and Outreach Evaluation Report	PROVTO	Quarterly
20	Physician Incentive Report	PHYINC	Annual - CY

#	REPORT TITLE	SHORT NAME	FREQUENCY
21	Grievances and Appeals Report	GANDA	Quarterly
22	Health Care Improvement Program	HCIP	Quarterly
23	Enrollee Satisfaction Survey Report	ENRSS	Annual - CY
24	Audited HEDIS Results Report	HEDIS	Annual - CY
25	Utilization Management and Integration Model	UMINT	Quarterly
27	Business Continuity and Disaster Recovery (BC-DR) Test Report	BCDR	Annual - PVCY
28	Unaudited Financial Statement	QTRFINSTA	Quarterly
29	Report on Controls Placed in Operation and Tests of Operating Effectiveness (SSA E 16)	CONTTEST	Annual - PVCY
30	Audited Financial Statements	AUDFINST	Annual - Contractor Fiscal Year
31	Cost Avoidance Report	COBAV	Quarterly
32	Report to Puerto Rico Insurance Commissioner's Office	ICANNSTA	Annual - CY
33	Annual Corporate Report	CORP	Annual - Contractor Fiscal Year
34	Pharmacy Certification	PHACER	Every two weeks
35	Incurred But Not Paid Report (IBNR)	IBNR	Quarterly

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Appendix 3 – Provider Specialty Code List

CODE	SPECIALTY
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
15	Speech Language Pathologist in Private Practice
16	Obstetrics / Gynecology
17	Hospice and palliative care
18	Ophthalmology
19	Oral Surgery
20	Orthopedic Surgery
21	Cardiac electrophysiology
22	Pathology
23	Sports medicine
24	Plastic and Reconstructive Surgery
25	Physical Medicine / Rehabilitation
26	Psychiatry
27	Geriatric psychiatry
28	Colorectal Surgery (Formerly Proctology)
29	Pulmonary Diseases
30	Diagnostic Radiology
31	Intensive cardiac rehabilitation

CODE	SPECIALTY
32	Anesthesiologist Assistant
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
42	Certified Nurse Midwife
43	Certified Registered Nurse Assistant (CRNA)
44	Infectious Disease
45	Mammography Screening Center
46	Endocrinology
47	Independent Diagnostics Testing Facility
48	Podiatry
49	Ambulatory Surgical Center
50	Nurse Practitioner
51	Medical Supply Company with Orthotist
52	Medical Supply Company with Prosthetist
53	Medical Supply Company with Orthotist-Prosthetist
54	Other Medical Supply Company
55	Individual Certified Orthotist
56	Individual Certified Prosthetist
57	Individual Certified Orthotist-Prosthetist
58	Medical Supply Company with pharmacist
59	Ambulance Service Provider
60	Public Health and Welfare Agency
61	Voluntary Health or Charitable Agency
62	Psychologist
63	Portable X-ray Supplier

CODE	SPECIALTY
64	Audiologist
65	Physical Therapist
66	Rheumatology
67	Occupational Therapy
68	Clinical Psychologist
69	Clinical Laboratory
70	Multi-Specialty Clinic or Group Practice
71	Registered Dietician / Nutritional Professional
72	Pain Management
73	Mass Immunization Roster Billers
74	Radiation Therapy Center
75	Slide Preparation Facilities
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
82	Hematology
83	Hematology / Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
87	All Other Suppliers
88	Unknown Supplier / Provider Specialty
89	Certified Clinical Nurse Specialist
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Intervention Radiology
96	Optician

CODE	SPECIALTY
97	Physician Assistant
98	Gynecological Oncology
99	Unknown Physician Specialty
A1	Skilled Nursing Facility
A2	Intermediate Care Nursing Facility
A3	Other Nursing Facility
A4	Home Health Agency
A5	Pharmacy
A6	Medical Supply Company with Respiratory Therapist
A7	Department Store
A8	Grocery Store
BB	Blood Bank
CV	Cardiac Catheterization Facility
DC	Center for Detoxification of alcohol and controlled substances
DD	Dentist
DF	Dialysis Facility
DM	Durable Medical Equipment (DME)
EC	Emergency Care Facility
EN	Endodontist
G1	Geneticist
HE	Health Educator
HN	Home Health Nurse
HO	Hospice
HV	HIV Ambulatory Antibiotic Facility
IC	Intensive Care Unit
IT	Infusion Therapy
LI	Lithotripsy
N1	Neonatology
NI	Neonatal ICU
O1	Occupational Medicine
OP	Optical
P1	Perinatology
P2	Pediatric Surgery

CODE	SPECIALTY
PC	Clinic - Primary Level
PE	Periodontist
PH	Private Hospital
PP	Private Psychiatric Hospital
PS	Psychiatric Partial Hospital
RT	Respiratory Therapist
SH	State Hospital
SP	State Psychiatric Hospital
ST	Short Term Intervention Center (Behavioral Health-Stabilization Unit)
UF	Urgent Care Facility
XR	X-ray Facility
Z4	Cardiovascular Surgery Program
BC	Behavioral Health

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