

**EXHIBIT E
REPORTING MATRIX**

#	Reference	Report	Description of Report	Report Breakout	Data Reporting Frequency	Measure	Perf. Stand. tied to a Sanction or Target tied to Withhold	Penalty for Sanction or % of Withhold	Generation of Report (State or Contractor)
1	Dashboard Report	Dashboard Report	Report for senior management of Department and ASO summarizing across all required reports all key trends, issues, or achievements that management should address or consider.	A	M	N/A	N/A	N/A	C
2	Access/Availability of Care	Adult Preventive Care	% members 20 yrs or older who had an ambulatory or prev. care visit (3 age stratifications)	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
3	Access/Availability of Care	Asthma Emergency Room	ED visits not leading to inpatient admission (req. enrollment for 6 mos prior to measure year- DSS specs.); Non-HEDIS	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
4	Access/Availability of Care	Children& Adol. Access to Primary Care	% of members 12 mos. - 19 yrs. who had a visit with a PCP. (4 age stratifications)	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
5	Access/Availability of Care	Prenatal & Postpartum care	% of deliveries of live births, that rec'd care in first trimester / 42 days of enrollment, % w/ timely postpartum visit	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
6	Access/Availability of Care	Ongoing Prenatal Care	% of deliveries that rec'd specified % of expected prenatal visits (5 groupings)	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
7	Access/Availability of Care	Mystery Shopper Surveys	Mystery Shopper Survey and Report – Contractor makes telephone calls to each of twenty five (25) randomly selected providers each quarter, with follow-up mystery shopper calls to low performing providers. E.g., assess whether provider is taking new patients, wait time to be accepted as new patient, wait time for appointments for established patients; by urgent, emergent and wellcare.	1	QY	Monitoring Indicator	TBD	TBD	C
8	Appeals	Provider Appeals and Determination Timeliness	<u>Level 1</u> : Total number of first level provider clinical appeals resolved by reason for appeal, during the reporting time period. Number and percentage resolved timely. Number and percentage overturned. <u>Level 2</u> : Total number of second level provider clinical appeals resolved by reason for appeal, during the reporting time period. Number and percentage resolved timely. Number and percentage overturned.	2	MQ	<u>Level 1</u> : Percentage of total child and adult appeals resolved timely; greater than or equal to 90%; <u>Level 2</u> : Percentage of total child and adult appeals resolved timely; greater than or equal to 90%	Performance Standard	\$1000/ Q for Level 1 and \$1000/Q for Level 2	C
9	Appeals	Member Appeals and Determination Timeliness	Total number of member clinical appeals resolved by reason for appeal, during the reporting time period. Number and percentage of member appeal determinations that met the 30 calendar day timeframe for routine appeals and the 3 day (5 day with a member meeting) timeframe for expedited appeals. Number and percentage overturned. Report all of above separately for routine and expedited appeals and combined.	2	MQ	<u>Level 1</u> : Percentage of total child and adult routine and expedited (combined) appeals resolved timely; greater than or equal to 90%;	Performance Standard	\$1000/ Q	C

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10	Appeals	Appeals - Administrative	Total number of administrative appeals resolved, by type of appeal for original denial, during the reporting time period. Number and percentage resolved timely (7 day timeframe). Number and percentage overturned.	2	MQ	Percentage of total child and adult appeals resolved timely; greater than or equal to 90%	Performance Standard	\$1000/Q	C
11	Authorization	Higher Levels of Care Timeliness Summary for Initial Auths - With & Without Peer Review	Number and percentage of cases that met the required timeframe broken out by approved, denied, partially denied, suspended or terminated. For those cases which did not meet the goal, the report shall include average time frame for completion. Summary Report that identifies the number and percentage of cases requiring higher levels of care and whether they are meeting the required timeframe for UM decision communication.	1	MQ	95% of decisions communicated within designated timeframe	Performance Standard	\$6,000/QT	C
12	Authorization	Lower Levels of care Timeliness Summary for Initial Auths -With and Without Peer Review.	Number and percentage of cases that met the required timeframe broken out by approved, denied, partially denied, suspended or terminated. For those cases which did not meet the goal, the report shall include average time frame for completion. Summary Report that identifies the number and percentage of cases requiring lower levels of care and whether they are meeting the required timeframe for UM decision communication.	1	MQ	95% of decisions communicated within designated timeframe	Performance Standard	\$6,000/QT	C
13	Authorization	Higher levels of Care Timeliness Report for Concurrent Reviews - With and Without Peer Review	Number and percentage of cases that met the required timeframe broken out by approved, denied, partially denied, suspended or terminated. For those cases which did not meet the goal, the report shall include average time frame for completion. Summary Report that identifies the number and percentage of concurrent review cases requiring higher levels of care and whether they are meeting the required timeframe for UM decision communication.	1	MQ	95% of decisions communicated within designated timeframe	Performance Standard	\$6,000/QT	C
14	Authorization	Lower levels of Care Timeliness Report for Concurrent Reviews - With and Without Peer Review	Number and percentage of cases that met the required timeframe broken out by approved, denied, partially denied, suspended or terminated. For those cases which did not meet the goal, the report shall include average time frame for completion. Summary Report that identifies the number and percentage of concurrent review cases requiring lower levels of care and whether they are meeting the required timeframe for UM decision communication.	1	MQ	95% of decisions communicated within designated timeframe	Performance Standard	\$6,000/QT	C
15	Authorization	Prior Authorization Request Report	By category and adult/child, the number of requests for PA, # denied, reason for denial, by category (inpatient & OP surg, DME, home care, PT/OT/ST/Chiro, pharmacy). Rx is limited to ASO managed such as home infusion.		QY	N/A	N/A	N/A	C

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16	Authorization	Authorization Timeliness	See Exhibit A Timeliness in passing authorization data to fiscal agent; timeliness in correcting authorization info errors; Accuracy in passing authorization data to fiscal agent, and accuracy in importing claims data from fiscal agent, as specified in Exhibit A	1	Q	See Exhibit A	Performance Target	See Exhibit A	C
17	Authorization	Timeliness of Authorization Decision Written Notification - Authorization letter extract	Summary report that identifies the timeliness of UM Decision Written Notification. 3.A summarizes authorization notification extract validity and completeness, i.e., the percentage of authorization records that resulted in an appropriate notification record on the authorization notification extract.	1	QY*	98% of all authorization decisions result in an appropriate notification contained in an authorization notification extract	Performance Standard	\$3,000/QT for first two quarters of the contract then \$1,500/QT	C
18	Call Mgmt.	Total Number of Calls	Total number of calls received by clinical queues, customer service queues, and crisis queue in the identified reporting time frame.	1	QY*	N/A	N/A	N/A	C
19	Call Mgmt.	Average Speed of Answer (ASA)	Average number of seconds to answer all calls with a live person coming into the call center including after hours calls and authorization lines, measured by the selection of a menu option (e.g.crisis queue).	1	QY*	30 seconds - clinical and customer service queues. 15 Seconds - Crisis queue.	Performance Standard	\$1,000/QT	C
20	Call Mgmt.	Call Abandonment Rate (CAR)	Total number and percentage of calls abandoned coming into the call center. Measured by each hour of the day and average for the month.	1	QY*	5%	Performance Standard	\$5,000/QT	C
21	Call Mgmt.	Calls Answered with in 30 Seconds	Total number and the percentage of calls coming into the call center answered within 30 seconds.	1	QY*	90%	Performance Standard	\$5,000/QT	C
22	Call Mgmt.	Busy No Answer	Total number of telephone calls and percentage of calls that reached a busy signal when calling into the call center.	1	QY*	Monitoring Indicator	N/A	N/A	C
23	Call Mgmt.	Number and Percentage of calls placed on hold and average length of time on hold for Clinical Services	Total number of telephone calls placed on hold and average length of time on hold.	1	QY*	5 minutes	Performance Standard	\$5,000/QT	C
24	Call Mgmt.	Number and Percentage of calls placed on hold and average length of time on hold for Customer Services	Total number of telephone calls placed on hold and average length of time on hold.	1	QY*	3 minutes; 1 minute for crisis calls	Performance Standard	\$5,000/QT	C
25	Call Mgmt.	Average length of time of call.	Average length of time of call.	1	QY*	N/A	N/A	N/A	C

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26	Call Mgmt.	Network Call Rerouting (NCR) Report	Report that documents each rerouting incident (including AVR transferred crisis calls) the answer time and the associated reason.	1	QY*	N/A	N/A	N/A	C
27	Capacity/Access	Gap Analysis	Perform a gap analysis and generate a density report to determine network inadequacies based on member/provider distance thresholds.	1	QY	N/A	N/A	N/A	C
28	Capacity/Access	PCP Panel Report	Lists providers functioning as PCPs and panel size. Monitor for providers with more than 1,200 members in their panel.	1	QY	N/A	N/A	N/A	C
29	Capacity/Access	Provider Participation	% increase in providers by type over past year	1	QY	N/A	N/A	N/A	C
30	Capacity/Access	Network Adequacy Analysis	Shows ratio of members to providers, by county, for identified providers types. Also shows members with more than specified distance to providers. Statewide report shall be issued only on demand, rather than at specified times. Urban/suburban/rural breakdown shall be used in the statewide report, but not in the area reports.	1	SA	Monitoring Indicator	TBD	TBD	C
31	Capacity/Access	Network Recruitment	Quantify the number of providers recruited by type and specialty and location	2	QY	Monitoring Indicator	TBD	TBD	C
32	Capacity/Access	Single Case Agreement	Number of Single Case Agreement requests, approvals, denials by category	1	QY	N/A	N/A	N/A	C
33	Capacity/Access	Board certified providers	% family med., internal med., peds., OB/GYN, geriatrician and other physician specialists whose board cert. is active 12/31	1	A (6/15)	N/A	N/A	N/A	C
34	Capacity/Access	Enrollment by product line	total number of members enrolled by age/gender	1	A (6/15)	N/A	N/A	N/A	C
35	Capacity/Access	Language diversity of membership	# and % members enrolled at any time in yr. by demand for language interpreter services and spoken language	1	A (6/15)	N/A	N/A	N/A	C
36	Capacity/Access	Race/ethnicity diversity of membership	# and % of members enrolled at any time in the year, by race and ethnicity	1	A (6/15)	N/A	N/A	N/A	C
37	Capacity/Access	Weeks of pregnancy at time of enrollment	% of women who delivered a live birth during the measurement yr and wks pregnant at time of enrollment to the organization	1	A (6/15)	N/A	N/A	N/A	C
38	Capacity/Access	Provider turnover	Produced for previous 6 months of activity. # providers beginning of time period, # at end, reasons for leaving a plan.	1	SA	N/A	N/A	N/A	C

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39	Cost of Care	Relative resource use for people with diabetes	Relative Resource Use (RRU) measures are a standardized approach to measuring relative resource use. When evaluated with the corresponding quality of care measures, they provide more information about the <i>efficiency</i> or <i>value</i> of services rendered by an organization. RRU measures have the following features. Focus on high-cost conditions that have corresponding HEDIS Effectiveness of Care measures. They differentiate between unit price and utilization variation. They rely on a transparent risk-adjustment method similar to a proprietary risk-adjustment system.	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
40	Cost of Care	Relative resource use for people with asthma	See above.	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
41	Cost of Care	Relative resource use for people with low back pain	See above.	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
42	Cost of Care	Relative resource use for people with cardiovascular conditions	See above.	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
43	Cost of Care	Relative resource use for people with hypertension	See above.	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
44	Cost of Care	Relative resource use for people with COPD	See above.	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
45	Effectiveness	Asthma medications	% of members 5-56 yrs. having persistent asthma & who were appropriately prescribed meds. (4 age stratifications)	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
46	Effectiveness	Breast Cancer Screens	% of women 40-69 who had a mammogram to screen for breast cancer. (2 age stratifications)	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
47	Effectiveness	Cervical Cancer Screens	% of women 21-64 years who received Pap test to screen for cancer.	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
48	Effectiveness	Chlamydia - FEMALE	% of women 16-24 identified as sexually active, and who had a test for Chlamydia (2 age stratifications)	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
49	Effectiveness	Chlamydia - MALE	There is no HEDIS measure for males. Follow ages used in HEDIS measure for women (Non-HEDIS)	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
50	Effectiveness	CIRTS (immunization database at DPH)	Calculate the % of children fully immunized by age 2. DPH sends HEDIS rates to DSS.	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C/DPH

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51	Effectiveness	Immunizations for Adolescents	First year measure 2010 - % 13 yr olds with specific vaccines	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
52	Effectiveness	Developmental Screening	Monitor developmental screening recommendation from AAP (3 specific ages for routine screen using validated tool) (Non-HEDIS)	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
53	Effectiveness	Diabetic retinal exams	% of members 18-75 yrs. with diabetes who had retinal eye exam performed (part of CDC HEDIS measure)	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
54	Effectiveness	Comprehensive Diabetes Care	% of members 18-75 yrs. with diabetes; included retinal exams, HbA1C, LDL-C & medical attention for nephropathy	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
55	Effectiveness	Gonorrhea	By gender, follow specs for Chlamydia	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
56	Effectiveness	Lead	% of 2 yr olds w/ 1 or more blood tests as specified	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
57	Effectiveness	Children w/ upper respiratory infections	% 3mos - 18 yrs olds diagnosed with upper respiratory infection & not dispensed antibiotics	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
58	Effectiveness	Adults with acute bronchitis	% of 18-64 yr olds diagnosed with acute bronchitis and not dispensed an antibiotic	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
59	Effectiveness	Pharmacotherapy of COPD exacerbation	% of COPD exacerbations for 40 yr olds or older, with acute inpatient discharge or ED 1/1 to 11/30 and were dispensed appropriate meds.	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
60	Effectiveness	Beta-blocker treatment	% members 18 yrs and older who were hospitalized and discharged alive 7/1 of yr prior to 6/30 of measurement yr with diagnosis of AMI and received persistent beta-blocker treatment	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
61	Effectiveness	Anti-rheumatic drug therapy	% of 18 yr olds and older diagnosed with rheumatoid arthritis & dispensed at least 1 ambulatory script for disease-modifying anti-rheumatic drug therapy	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
62	Effectiveness	C-Sections	Number of C-Sections and total number of vaginal deliveries (1 delivery regardless of # of babies delivered)	1	QY	TBD	TBD	TBD	C
63	Effectiveness	Fetal deaths	Number of single live births, non live births and multiple births (twins =2, triples=3 etc.)	1	QY	TBD	TBD	TBD	C
64	Effectiveness	Birth weight	Birth weight - to be obtained from birth certificates	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	S
65	Effectiveness	Low back pain	% of members (18 - 50 yrs.) with primary diagnosis of low back pain who did not have an imaging study within 28 days of diagnosis	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C

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66	Effectiveness	ADHD medication follow up	% of children newly prescribed ADHD meds. With at least 3 follow up visits in 10 month period - 1 w/in 30 days.	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
67	Effectiveness	Persistent medications	% of 18yrs and older rec'd at least 180 treatment days of ambulatory medication therapy for select agents during yr & at least 1 therapeutic monitoring event (ARB< digoxin, diuretics, anticonvulsants)	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
68	Finance	Budget to Actual Report	The Contractor shall produce a budget to actual report within 45 days of the close of each quarter showing line item expenditures against the quarterly and annual contract maximum in the budget format established in Exhibit F of the RFP.	1	QY	N/A	N/A	N/A	C
69	Finance	Audited Financials	The Department shall conduct a final reconciliation of the payments received by Contractor against actual expenditures as reported in the audited financial statements or agreed upon procedures required to be submitted by the Contractor.	1	A (4/15)	N/A	N/A	N/A	C
70	ICM	ICM Actives	Summary report of individuals served by ICM, average length of stay, and other statistics.	3	MQ	N/A	N/A	N/A	C
71	NOA/ Denials	Total Number of NOAs and Denials issued	This report reflects the number of NOA's and Denials issued for lack of Medical Necessity or coverage within the designated reporting period. The report is broken by Adult/Child cases, and Levels of care based on the type of NOA/Denial issued. This version does not contain administrative denials. Quarterly totals and YTD totals also include a count of NOAs/Denials per 1000.	2	MQ	NA	NA	NA	C
72	NOA/ Denials	Total Number of Administrative Denials issued	This report reflects the number of administrative Denials issued within the designated reporting period. The report is broken by Adult/Child cases, and Levels of care based on the type of Denial issued. This version contains only administrative denials. Quarterly totals and YTD totals also include a count of Denials per 1000.	2	MQ	NA	NA	NA	C
73	NOA/ Denials	Reduction Summary Report ***	Report will include all service requests that did not meet medical necessity requirements and for which authorization was provided for a reduced level of care. This report shall be broken out by level of care requested and the resulting level of care that was authorized.	2	MQY	N/A	N/A	N/A	C

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74	NOA/ Denials	Percent and number of NOAs and Denials issued within 3 days	Report consistent with attached template. The number and percentage of NOAs and Denials that were issued within three days of the decision (U.2.9). NOAs and Denials reported separately.	1	MQY	98% within three business days	Performance Standard	\$2000/Q	C
75	NOA/ Denials	Denial Detail Report	Individual record of every medical necessity denial coded by type and by reason	1	MQ	NA	NA	NA	C
76	NOA/ Denials	Denial to Hearings Report	Report reflects the # of PAs requested, # denied, # proceeding to hearing and the outcome of the internal review & the hearing	Medicaid only	SA	NA	NA	NA	C
77	QM	Critical Incident Reporting	Total number of cases and incident type. Broken out by provider, incident type, summary of incident, action taken and outcome of action.	2	A	Monitoring Indicator	N/A	N/A	C
78	QM	Complaints Meeting Turnaround Time (TAT) and Average Amount of Time to Resolve Complaints (in Days) by Quarter	Total number of provider and member complaints received and the percent that were responded to appropriately within 30 days or 45 days with an extension requested. Broken out by provider and member. Second part reflects average time taken to respond to complaints. This report summarizes unduplicated complaints processed within the time period. In addition, it indicates the number of complaints received monthly and year to date and breaks out by the caller category. The reports reflects total number of provider and member complaints resolved and the percent that were resolved within the time frame of 30, 45 and over 45 days. This report also identifies the average amount of time taken to resolve complaints (measured in days). This report indicates the number of complaints that remain open at the end of the time period. (Current) indicates the number of complains that remain open at the time of the report run date.	2	M	Performance Standard	Performance Standard	\$2000/ Quarter	C
79	QM	Complaints broken out by reason code.	Complaints received YTD by complaint reason and received month. Broken down by provider vs. member. Summarized Complaints received year-to-date by Complaint Reason and received month. See attached template.	2	MQ	N/A	N/A	N/A	C
80	Satisfaction	CAHPS	Customer satisfaction survey (includes questions for adult, child and chronic child) - Statewide	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
81	Satisfaction	CAHPS - PCMH/HH specific	Customer satisfaction survey (includes questions for adult, child and chronic child) - PCMH/HH specific	1	A (6/15)	TBD	TBD	TBD	C

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82	Satisfaction	Brief Member Services Survey	Brief phone interview with random sample of 400-500 members who contacted the ASO's call center for assistance (N.5.2.1.3)	1	A (6/15)	Performance Target	Exhibit A, Year 1	See Exhibit A	C
83	Satisfaction	Provider Satisfaction Survey	Survey that examines provider's satisfaction with the Contractor's services and other administrative services provided by the state or its agents including but not limited to authorization procedures, courtesy and professionalism, network management services, provider appeals, provider education, referral assistance, coordination, claims processing as administered by the Department's MMIS) and overall administrative burden (see N.6.1)	1	A (4/30)	Performance Target	Exhibit A, Year 1	See Exhibit A	C
84	UM	Bypass Program	Reports that enable the monitoring of the bypass program; allows review of performance of each participating and non-participating provider with respect to average length of stay and performance on quality metrics (if applicable) in comparison with overall performance of providers statewide for the target level of care.	2	QA	TBD	TBD	TBD	C
85	UM	Utilization Statistics	Monthly auth-based utilization statistics by LOC with summary. Includes admissions, admissions/1000 member months, days/1000 member months, and average and Median LOS. Each program will be reported in a separate report. Monthly authorization-based utilization statistics by age group and level of care, with quarterly and year-to-date subtotals.	2,3	QY*	TBD	TBD	TBD	C
86	UM	Consistency of UM Decision Making among Contractor Staff	Include total number of clinical staff being tested (including all psychiatrists making medical necessity decisions) and test score percentage. To report pass/fail, not specific scores.	1	QY	Monitoring Indicator	N/A	N/A	C
87	Use of Services	Ambulatory Care	Utilization of outpatient visits, ED visits, ambulatory surgery/ procedures, and observation room stays per 1,000MM	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	S
88	Use of Services	EPSDT Screening Ratio, Participation Ratio - CMS 416	Children's participation and screening ratio for well care, dental utilization and lead screenings (NON-HEDIS)	Medicaid only	A (4/01)	Performance Target	Exhibit A, Year 2	TBD	C
89	Use of Services	Inpatient Utilization	Utilization of acute inpatient services: total inpatient, medicine, surgery, & maternity - discharges per 1,000 MM, ALOS, days per 1,000MM	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
90	Use of Services	Well child - first 15mos. Of life	% of members who turned 15mos. during yr & total # of well child visits they had	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
91	Use of Services	Well-child visit (3rd-6th yr of life)	% of 3-6 yr olds with 1 or more well child visits w/ PCP	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C

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92	Use of Services	Adolescent Well-Care Visits	% of 12-21 yr olds with at least 1 comprehensive well care visit with a PCP or OB/GYN practitioner	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
93	Use of Services	Neonatal intensive care unit admissions	NICU admissions per 100 births (DSS specs, Non-HEDIS)	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
94	Use of Services	ED usage	ED utilization per 1,000 MM (DSS specs, Non-HEDIS)	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
95	Use of Services	Readmission rates	Readmission for same or similar diagnosis within 7 days of discharge (DSS specs, Non-HEDIS)	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
96	Use of Services	All-Cause Readmission Measure	Tracks reasons for hospital readmissions with plans and adjusts rates based on past comorbidities, primary discharge conditions, presence of major surgery, age and gender.	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
97	Use of Services	Frequency of selected procedures	utilization of freq. performed procedures PMPM: CABG tonsillectomy, back surgery, mastectomy, knee or hip replacement, carotid endarterectomy etc.	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
98	Use of Services	Identification of alcohol & other drug services	number and % of members with alcohol & drug claims who rec'd chemical dependency services: any, inpatient, intensive outpatient or partial hosp., outpatient or ED (although not an ASO managed service, we are proposing to include this HEDIS measure in ASO scope).	1	A (6/15)	N/A	N/A	N/A	C
99	Use of Services	Antibiotic utilization	outpt. utilization of antibiotic prescriptions by age, gender, total days, total scripts	1	A (6/15)	Performance Target	Exhibit A, Year 2	TBD	C
100	Use of Services	Inpatient Daily Census Report	A listing of all members in 24-hour care sortable by: name, ID, facility, facility type, local area, date of admission, length of stay, DX, DCF identifier, gender, race/ethnicity, provider, and program ID. This is a	1	D	N/A	N/A	N/A	C

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		<u>Report Breakout Legend</u>								
1		Report summarized by all enrollment								
2		Report summarized by Child (<18) vs. Adult (18+)								
3		Report summarized by aid category (FAMILY, ABD, LTC, LIA, CHIP, COAK)								
4		Report summarized by PCMH, HH, and ICO								
		<u>Data Reporting Frequency Legend</u>								
A		Annual								
BW		Bi-weekly								
D		Daily								
M		Monthly with quarterly and year-to-date subtotals								
Q		Quarterly								
MQ		Quarterly report with breakdown by month and quarter subtotals								
MQY		Quarterly report with breakdown by month, quarter and year-to-date subtotals								
QY		Quarterly report with year-to-date subtotals								
SA		Semi-annual								
W		Weekly with monthly subtotals								
		<u>Generation of Report Legend</u>								
C		Contacting								
S		State								
*		Implementation Reporting Requirement - Measure may be required more frequently during the implementation period.								
		Note 1: All reports submitted on a quarterly and annual basis will require the Reporting and Performance Measure Data Analysis form.								
		Note 2: The Departments will generate additional reports related to pharmacy, dental, and behavioral health.								
		Note 3: The Contractor will be required to exclude dual eligible clients from all reports for which Medicaid is not primary payer (e.g., hospital inpatient).								
		Note 4: We have made an effort to designate reports that appear to be HEDIS but are not HEDIS with the designation "DSS specs" or "non-HEDIS"								

**EXHIBIT E
REPORTING MATRIX**

Performance Measure Data Analysis Form to be completed by the Contractor for all reports submitted on a quarterly, bi-annual or annual basis.

Quality Improvement Activity:	Supporting Graphs including plotted goals, performance, benchmarks.
Reporting Frequency:	
Rationale for Performance Measure:	
Data Source:	
Goal:	
Measurement (methodology/sample size):	
1st Quarter Analysis of results:	1st Quarter Intervention(s)
2nd Quarter Analysis of results:	2nd Quarter Intervention(s)
3rd Quarter Analysis of results:	3rd Quarter Intervention(s)
4th Quarter Analysis of results:	4th Quarter Intervention(s)
Annual Analysis of results including accomplishments, barriers and conclusions	Annual Intervention(s)

Prior Authorization Request & Determinations

MCO Name: _____

Program: _____

Reporting period: _____

Total MM, Clients under age 21 _____

Total MM, Clients age 21 or older _____

	Approvals	Denials	Partial Denials	Approvals per 1,000 MM	Denials per 1,000 MM
Inpatient Services and Outpatient Surgery					
a) Not consistent with generally accepted standards of medical practice;					
b) Not clinically appropriate in terms of type, frequency, timing, site and duration;					
c) Not primarily for the convenience of the individual or provider.					
d) Not more costly than an alternative service(s) likely to produce equivalent results.					
e) Not based on assessment of the individual and their medical condition					
f.) other (please specify)					

	Approvals	Denials	Partial Denials	Approvals per 1,000 MM	Denials per 1,000 MM

	Approvals	Denials	Partial Denials	Approvals per 1,000 MM	Denials per 1,000 MM
Durable Medical Equipment					
a) Not consistent with generally accepted standards of medical practice;					

	Approvals	Denials	Partial Denials	Approvals per 1,000 MM	Denials per 1,000 MM

b) Not clinically appropriate in terms of type, frequency, timing, site and duration;					
c) Not primarily for the convenience of the individual or provider.					
d) Not more costly than an alternative service (s) likely to produce equivalent results.					
e) Not based on assessment of the individual and their medical condition					
f.) other (please specify)					

	Approvals	Denials	Partial Denials	Approvals per 1,000 MM	Denials per 1,000 MM
Home Health					
a) Not consistent with generally accepted standards of medical practice;					
b) Not clinically appropriate in terms of type, frequency, timing, site and duration;					
c) Not primarily for the convenience of the individual or provider.					
d) Not more costly than an alternative service (s) likely to produce equivalent results.					
e) Not based on assessment of the individual and their medical condition					
f.) other (please specify)					

Approvals	Denials	Partial Denials	Approvals per 1,000 MM	Denials per 1,000 MM

	Approvals	Denials	Partial Denials	Approvals per 1,000 MM	Denials per 1,000 MM
Therapies (OT, PT, Speech, Chiropractor)					
a) Not consistent with generally accepted standards of medical practice;					

Approvals	Denials	Partial Denials	Approvals per 1,000 MM	Denials per 1,000 MM

b) Not clinically appropriate in terms of type, frequency, timing, site and duration;					
c) Not primarily for the convenience of the individual or provider.					
d) Not more costly than an alternative service (s) likely to produce equivalent results.					
e) Not based on assessment of the individual and their medical condition					
f.) other (please specify)					

	Approvals	Denials	Partial Denials	Approvals per 1,000 MM	Denials per 1,000 MM
Pharmacy					
a) Not consistent with generally accepted standards of medical practice;					
b) Not clinically appropriate in terms of type, frequency, timing, site and duration;					
c) Not primarily for the convenience of the individual or provider.					
d) Not more costly than an alternative service (s) likely to produce equivalent results.					
e) Not based on assessment of the individual and their medical condition					
f.) other (please specify)					

Approvals	Denials	Partial Denials	Approvals per 1,000 MM	Denials per 1,000 MM

	Approvals	Denials	Partial Denials	Approvals per 1,000 MM	Denials per 1,000 MM
All Other					
a) Not consistent with generally accepted standards of medical practice;					

Approvals	Denials	Partial Denials	Approvals per 1,000 MM	Denials per 1,000 MM

b) Not clinically appropriate in terms of type, frequency, timing, site and duration;					
c) Not primarily for the convenience of the individual or provider.					
d) Not more costly than an alternative service (s) likely to produce equivalent results.					
e) Not based on assessment of the individual and their medical condition					
f.) other (please specify)					

Age listed is that as of date of the request.

* Partial Denials were partially approved and partially denied.

Monthly Authorization Denial Report _____

PA actions during month of: _____

	Aid Category	Member ID	age	service requested	diagnosis	partial denial (Y/N)
1						
2						
3						
4						
5						
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**reason for
denial (a-e, see
key) alternative service authorized (if any) comment**

Provider Access # /1000MM

No access: location, closed panel, selection, no par prvdr in area, etc.		
PCP		
Specialist		
Hospital		
Delayed access: excessive wait time to appointment		
PCP		
Specialist		
Hospital		
Total		

Reporting Period _____

Program: _____

Total MM _____

Quality of Provider Services # /1000MM

Provider conduct/professionalism (clinician or staff)		
condition of office/facility		
inappropriate care		
language		
bias		
cultural		
handicap		
Total		

Quality of ASO Services # /1000MM

Quality of MCO customer svc		
Member materials		
Provider panel list		
Total		

Financial # /1000MM

Member Billed		
Cost share		
COB		
Premium		
Band 1		
Band 2		
Band 3		
Band 4		
Band 5		
Maximums		
DME		
Pharmacy		
Annual		
Lifetime		
Total		

Other	#	/1000MM
Fraud		
member		
provider		
Carved out service		
Out of State Pharmacy		
No Temporary Supply - Pharmacy		
Pharmacy - all other		
Dental		
Behavioral Health		
Other		
Total		
TOTAL Grievances		