NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) REPORTING MANUAL

Contract Year 4
June 2021-May 2022

Office of Medicaid Policy and Planning
Version CY4.02

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CHANGE HISTORY

Version	Released	Summary of Changes
CY4.01	**June 2021**	This version replaces all previous manuals and templates. The effective date for this version is June 1, 2021.
CY4.02	**July 2021**	Added definitions of valid and substantiated for complaint reporting purposes. Add a summary of the new monthly dashboard for consistent instructional purposes.

INTRODUCTION

This manual provides information by the Office of Medicaid Policy and Planning (OMPP) on required performance reporting for Southeastrans (SET), FSSA's contracted Broker entity for Non-Emergency Medical Transportation Services (NEMT) for eligible Fee-for-Service (FFS) members. All references to "Broker" throughout the reporting manual apply to Southeastrans (SET). It is the responsibility of the Broker to accurately, completely, and timely report all delegated performance data.

This manual was reviewed in full and updated in the Spring of 2021 with consultation between OMPP Strategy Team, policy/reporting liaisons and NEMT staff, Broker staff, and subject matter experts. A detailed change history is included to highlight items that have been removed, consolidated, updated, and/or added.

The majority of the reports utilize an MS Excel template developed by the OMPP. The provide Excel workbooks contain all required templates:

- The **Weekly Report Workbook** contains templates for all weekly reports. This workbook must be updated and submit as is.
- The **Monthly Report Workbook** contains templates for most monthly reports. This workbook must be updated and submit as is.

Note, there is no template for the Regional Gaps report, the monthly Vehicle by County Map, or for the Annual Program Integrity report. This report must be completed in MS Word and contain all the components **detailed in the corresponding report summary.** the broker must follow all naming and submission rules.

Color Coding Used in the Reporting Manual

The in all reporting workbooks color-coding has been applied to indicate column headings and cells in each report:

	Titles and intentional blank space
	Headers & Explanatory text
	Fields that the Broker is to fill ln
	Calculation fields

Report Catalog

The Report Catalog appears in the Table of Contents of this document. Corresponding catalogs also appear in a tab at the front of the Weekly and Monthly Report workbooks. A general description and breakdown of data elements for each report are included in this manual.

GENERAL REPORTING REQUIREMENTS

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

The Broker may submit report data earlier than the actual date the data is due. However, OMPP will consider the data late if OMPP does not receive the data electronically in the designated email box (**NEMT1@fssa.IN.gov**) by 5:00 pm (Eastern Time) on the date due. If the deadline falls on the weekend, it is due the first business day following the deadline.

If the Broker fails to provide report data as required, OMPP may consider the submission non-compliant and may assess liquidated damages or other remedies as described in the applicable Contract.

Reporting Periods and Frequency

There are several time periods that are taken into account when determining the report submission timeline and frequency:

Experience period: This is the actual period of time, or incurred dates of service, for which the reporting activity took place.

Reporting period: The reporting period is defined as the submission timeframe and might not be the same as the experience period.

Claims-lag period: The claims lag is a duration of time, typically 90 days, which is allowed to transpire prior to reporting an activity or service. Submission of claims may take several weeks or months to be captured in a Broker's data warehouse after the date of service has taken place. Allowing for a claims lag prior to counting the activity or service, helps to ensure that the data truly represents all information regarding that experience period.

Annual and Year to Date (YTD) reporting will be designated as either a Contract Year (June 1 through May 31) or the calendar year. Some monthly reports also require a YTD cumulative update.

Report Submission

All report files are to be submitted via SECURE emailed to NEMT1@fssa.IN.gov; files should not be sent directly to individual OMPP staff members except as designated. Data protection and security guidelines must be followed to the fullest extent to protect members'

personal health information (PHI).

The Broker should not include any data or analytic charts in the body of the email. Any information submitted in the body of the email will not be considered or accepted as an official submission. If desired, the Broker may attach data analytics and/or comments along with the data workbook, but may not submit such information in lieu of the workbook. Any additional data analytics and/or comments must be submitted in MS Word, MS Excel, or PDF format.

File Naming

The Broker must adhere to OMPP naming conventions, file submissions, and re-submissions requirements.

The nomenclature for submitting the **Weekly Reports** is as follows:

NEMT_ [Year]_[Month][Week#]_[Version #]

Year = the calendar year

Month= the 3 letter abbreviation for the month related to report submission

Week # = the number (1-5) that indicates the numerical status of the week within the month.

Version number = the initial submission (1), resubmission (2) etc.

Submission Example: Initial submission of the Weekly Reports due is due September 7, 2020. The filename for this submission is**: NEMT_ 2020_SEP1_1**

The nomenclature for submitting the **Monthly Reports** is as follows:

NEMT_ [Year]_[Month]_[Version #]

Year = the calendar year

Month= the 3 letter abbreviation for the month related to report submission

Version number = the initial submission (1), resubmission (2) etc.

Submission Example: Initial submission of the Monthly Reports due is due September 15, 2020. The filename for this submission is**: NEMT_ 2020_AUG_1**

The nomenclature for submitting an **Annual Report** is as follows:

NEMT.AN [year] [version number]

Year= the year related to report submission

Version number = the initial submission (.01), resubmission (.02) etc.

Submission Example: Initial submission of the Annual Program Integrity Plan Report (#1104) due in January 2021. The filename for this submission is**: NEMT_AN_2020_01**

Resubmission and Version Control

After submission, if OMPP or the Broker determines that information has been omitted or is inaccurate, amended data may be requested and accepted. ***The OMPP NEMT Director should be contacted by email or phone upon discovery and prior to resubmission***. If the Broker needs to resubmit reports after version 1, then the Broker should do the following:

- Start with the Excel file submitted and 'Save As', rename the file with _2.
- Change the Attestation form by changing the Date of Submission of the _2 file.
- Enter the new date that indicates the resubmission date in the v2 columns, but only on the specific reports that are being updated. Do not enter a date in any cell for a report that is not being updated. That is an indicator to the reader that no changes were made to these reports.
- Repeat this process if a _3 version of the file is necessary.
- The file upload must be accompanied by an email message to the NEMT unit email box indicating the name of the report(s) being updated and resubmitted

Attestation

The Broker is required to have its Chief Executive Officer or an authorized designee sign the Attestation form with the submission of every report submission. Designees must be clearly identified on the Key Staff report. The Attestation is a **separate file** that covers all reports submitted for the reporting month, including weekly and ad-hoc reports. In January of each year, the attestation file will also cover the Annual Program Integrity Plan Report.

Data Related Comments to OMPP

There is a separate *Comments* tab where the Broker can write specific comments pertaining to any report in the Weekly and Monthly Report workbook. Issues such as data anomalies, incomplete data, or large changes from prior periods should be included in this tab. If the Broker chooses, a separate document with comments may be submitted in addition to the reporting workbooks. For any comments not related to the data on a report, the Broker should submit a separate email directly to the OMPP Director of Vendor Management **and** the NEMT Vendor Manager.

Report Extension

Occasionally, the Broker may encounter issues that may prevent timely submissions of its report data. To request an extension, the Broker must submit a written request to the NEMT Director at least **one full business day** before the data is due. If an error is discovered during the day of the data submission, **DO NOT knowingly submit the incorrect data**. Please contact OMPP by phone immediately upon discovery seeking an extension regardless of the discovery being past the one full business day rule. The phone call must be followed by a detailed email to OMPP explaining what happened. Extensions are granted at OMPP's discretion and will be given a verbal response over the phone along with an email response confirming OMPP's decisions. OMPP may consider the Broker's reporting data submission as untimely if the request does not follow the prescribed protocol. The granting of an extension is solely at OMPP's discretion. If the extension request is denied, OMPP will consider submission untimely if not submitted by the required due date.

FINES/ LIQUIDATED DAMAGES

If Contractor fails to submit in a timely, complete, and accurate manner any report, which Contractor is required to provide under the Contract or Contracting Reporting Manual, Contractor will pay liquidated damages of **$500 PER REPORT for EACH BUSINESS day** for

which such report has not been submitted correctly, complete, on time and in the correct reporting format.

PERFORMANCE STANDARDS

Reporting Feedback

OMPP may provide feedback to the Broker regarding its performance reporting data. Feedback may include confirmation letters upon receiving the performance data; observations for which OMPP requires additional explanation or mitigation activities; graphics displaying the Broker's performance compared to OMPP standards, national benchmarks, or other participating Brokers' performance, as appropriate. At OMPP's discretion, the OMPP Reporting Analyst, OMPP Member Services Manager, and/or other OMPP data analysts may discuss performance reports or any other data during the Broker's regular on-site visits or at any other time as needed.

OMPP may schedule meetings or conference calls with the Broker upon receiving the Broker's performance data. When OMPP identifies potential performance issues, the Broker must formally respond in writing to these issues within the timeframe designated. If the Broker fails to provide a formal, written response to the feedback or fails to respond within the requested timeframe, OMPP may consider the Broker non-compliant in its performance reporting and may implement corrective actions.

Performance Metrics & Reporting Method

The following performance metrics and standards, as outlined in the Broker's contract shall be used to evaluate the program's effectiveness and success, as well as to determine the Broker's eligibility for any Pay for Outcomes incentives and/or penalties. Please see the current contract amendment for details on Pay for Outcomes.

NEMT REPORTING DEFINITIONS

All NEMT Operations reports are to use the following definitions.

Claims and Operations Definitions

Claim: A claim is a billing encounter notice submitted for reimbursement consideration or a health care utilization document that itemizes health care service(s) (i.e., claim line items) that have been rendered to a member.

CMS 1500 Claim: The nationally recognized claim form for the submission for payment of professional services. Under HIPAA, electronically submitted professional claims are referred to as 837P claims. Unless specifically indicated otherwise, the term CMS 1500 is used for either paper or electronically submitted professional claims.

Clean Claim: A claim in which all information required for processing the claim is on the claim form. The following are examples of claims that DO NOT meet the definition of a Clean Claim:

- Rejected claims
- Replacement or adjustment claims
- Misdirected claims
- Claims for members not currently enrolled
- Claims for which the broker is not financially responsible
- Unclean claims that require additional information
- Pended or suspended claims

Adjudicated Clean Claim: An original claim that has been received by the Broker and processed through its claims system to a "paid" or "denied" decision status.

Adjudicated clean claims should **NOT** include any claim does not meet the Clean Claim definition.

Clean Claim Paid on Time: For electronically submitted claims, a clean claim is paid on time when it is paid within 30 calendar days of the Broker's receipt. For paper submitted claims, a clean claim is paid on time when it is paid within 30 calendar days of the Broker's receipt.

Clean Claim Paid Late: For electronically submitted claims, a clean claim is paid late when it is paid more than 30 calendar days after the Broker's receipt. For paper submitted claims, a clean claim is paid late when it is paid more than 30 calendar days after the Broker's receipt.

Paid Clean Claim: A paid claim is a billing encounter notice submitted for reimbursement

consideration or (health care) utilization documentation that itemizes (health care) service(s) (i.e., claim line items) rendered to a covered person eligible to receive the (health care) service(s) on the date rendered in which at least one of the (health care) services **(i.e., a claim line item(s))** is **either partially or fully** reimbursable or deemed eligible for full or partial reimbursement if the submitting entity had not been pre-paid for the (health care) service(s

Denied Clean Claim: A denied claim is a billing encounter notice submitted for reimbursement consideration or health care utilization documentation that itemizes health care service(s) (i.e., claim line items) rendered to a person in which ALL the health care service(s) **(i.e., claim line item(s)) are deemed NOT eligible/appropriate for reimbursement**.

Unclean Claim: A claim in which fails to include all the information required for processing is per IC 12-15-13.0.6.

For FSSA reporting purposes this includes:

- Claims received, but denied by the Broker because the claim failed to pass HIPAA compliance edits. These claims will not pass the fiscal agent's pre-adjudication edits for encounter submissions.
- Claims that do not have the National Provider Identifier. These claims are treated as a rejected claims, regardless of whether the Broker accepts the claim into its inventory system.
- A final decision regarding the service cannot yet be made due to a lack of information.

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

Rejected Claim: A claim that the Broker cannot accept into its inventory for future adjudication or accepts into its inventory but FSSA has specified should be treated as a rejected claim. Rejected claims should not be submitted to FSSA in the encounter data process. For purposes of this report, rejected claims and unclean claims should be treated the same.

Rejected claims should include the following scenarios:

- Misdirected claims: a claim submitted to the wrong entity for processing (e.g., claim submitted to the wrong broker)
- Claims for members not currently enrolled
- Claims for which the broker is not financially responsible
- Unclean claims (a claim in which all the information required for processing is not present – per IC- 12-15-13.0.6)

Received Claim: A claim the Broker has accepted into its inventory management system for future adjudication. For the purposes of this report, rejected claims and replacement claims are

not considered received claims.

Replacement Claim: A claim the Broker has previously adjudicated but has been resubmitted for reprocessing (i.e., adjustment). This adjustment may be due to a provider correction regarding the original submission. If a replacement claim is received, it is not considered as an original clean claim for reporting purposes.

Remittance Advice (RA) Date: The date the Broker generates the provider remittance advice for an adjudicated claim. This is the date the provider's check or EFT is remitted to the provider and sometimes referred to as the paid date.

Member Service Definitions

Complaints - any concerns related to the delivery of transportation, such as dissatisfaction with the quality of care or services received, provider or provider staff conduct (such as rudeness), or the failure to respect an enrollee's rights.

Appeal – The right of a member to request a review of a decision by the FSSA Office of Hearings and Appeals, when the initial decision results in any of the following:

- The denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner
- The failure to act within the required timeframe
- The failure to allow a resident of a rural area to obtain services outside the network

Appeal Right: If the matter requires that the Broker review the situation and supply a decision, the complaint should include appeal rights if the subsequent decision is an adverse determination.

High-Risk Members (HRM) - members who have trips associated with dialysis, surgery, wound care, or chemo/radiation (either standing orders or demand) and/or other conditions who require have the assurance that their transportation will be carefully managed.

MCA (Member Care Advisory) – These members have been identified as needing special care at a higher priority where their transport schedule is carefully managed. The consideration for assignment to the MCA list includes the following:

- 2nd Missed appointment
- 1st Missed appointment for dialysis and other critical services
- Significant complaint(s) by the member, medical provider, or facility regarding service

- Request by the contracting agency (State, MCO, Regulatory) staff to be placed on the list

Resolved - an answer or solution has been found and no further action is needed.

Substantiated - to establish by proof or competent evidence. For the specific purpose of Medicaid NEMT, a complaint is substantiated there is sufficient evidence that indicates the event/situation occurred as reported and/or that there was a clear adverse outcome for the member. *Note: Only valid complaints can be substantiated.*

Example 1: A member says that the driver was smoking in the vehicle. Upon review the dash camera shows the driver smoking; thus the complaint is substantiated.

Example 2: A member claims that SET did not sufficiently work their request resulting in a missed trip. The complaint is substantiated if either the trip was not properly worked **or** if it was worked but no provider was assigned and the trip was in fact missed.

Valid - well-grounded or justifiable: being at once relevant and meaningful, i.e. a valid theory; or to be logically correct. For the specific purpose of Medicaid NEMT, a complaint is considered valid if comes from or is made on behalf of a Fee-for-Service member(s) **and** contains an expression of dissatisfaction about any aspect of NEMT service delivery, regardless of to whom or how the complaint was registered.

Example 1: A fee-for-service member contacts their legislator because they are disappointed in the Broker's past service and concerned about their future access to transportation for medical appointments. This is a valid complaint even if trip history is positive because the member expresses dissatisfaction with the program.

Example 2: A member who is not enrolled in FFS files a complaint that SET will not provide services to him/her. This complaint is not valid because the member is not eligible for services under this contract.

WEEKLY REPORTS

1. Claims Processing Summary
2. Call Center Detail
3. HRM/MCA Report
4. Member No-Shows
5. Network Development
6. Provider No-Shows Detail
7. Send backs Detail

Weekly Claims Processing and Adjudication

General Report Description	
Purpose	Document and track weekly claims submissions and payments
Frequency	Weekly
Data Elements	
Item 1	Week Ending date
Description	Broker enters the last date of the week for which the data is reported
Item 2	# Paper Claims Submitted
Description	Number of claims submitted during the reporting period via paper, regardless of trip date
Item 3	# Electronic Claims Submitted
Description	Number of electronically submitted claims during the reporting period, regardless of trip date.
Item 4	Total Claims Submitted
Description	Total claims submitted (sum of Paper and Electronic Submissions) during the reporting period, regardless of trip date.
Item 5	% Claims Submitted Electronically
Description	The percentage of total claims that were submitted electronically for the week
Item 6	# Claims Paid
Description	# Claims paid by Broker
Item 7	# Claims Denied
Description	# Claims denied by Broker
Item 8	% Claims Paid
Description	Percentage of total claims paid by Broker for the week.
Item 9	Comments
Description	Comments regarding any atypical numbers (unusual denial reasons or numbers, significant increase or decrease in claims or submission methods, etc.) If none, leave blank.

Weekly Call Center Performance

General Report Description	
Purpose	To monitor the Broker's provision of quality call center services.
Legal Reference	IC 12-15-30.5-4 (a)(3)(B)
Frequency	Weekly
Data Elements	
Item 1	All Lines Number of Total Calls
Description	The total number (whole numbers only) of calls received by All Lines listed during hours of operation. This includes: • Inbound calls directly from a member, provider, facility, or other entity • Transfers into the Member Helpline or other appropriate line • The member or other entity selects an option placing the member into the automatic call distribution (ACD) call queue. • Calls to each line (WMR, Facility, CSR, NF, QA, Provider)
Item 2	All Lines Weekly Average Speed to Answer (ASA) Total Calls
Description	Number reflecting average speed, in seconds, for call center staff to answer.
Item 3	All Lines Weekly Average Handle Time (AHT) Total Calls
Description	Amount of time reflected in seconds to complete the call
Item 4	Total Number of Total Calls Abandoned Weekly
Description	Number of calls weekly received into all lines during hours of operation that were abandoned (disconnected) by the caller or the system before being answered.
Item 5	Percent of Calls Abandoned
Description	Percent of total calls that are abandoned. The Formula is # of Abandoned calls [DIVIDED BY] # Number of total calls
Item 6	Weekly Number of Calls Resolved on the First Call
Description	Number of member calls that were resolved during the initial call.
Item 7	Percent of Member Calls Resolved during the Initial Call
Description	This is an auto-calculated field. The formula is *# of resolved on the initial call [DIVIDED BY] #of calls received.*

Item 1	CSR Line
Description	The number of calls (whole numbers only) received by the CSR Line during hours of operation. This includes: • Inbound calls directly from a member or representative, (or provider, facility, or other entity that might have been misdirected to this line) • Transfers into the CSR Line or other appropriate line
Item 2	CSR Calls ASA
Description	Number reflecting average speed, in seconds, for call center staff to answer for the CSR line.
Item 3	CSR Calls AHT
Description	Amount of time reflected in seconds to complete the call on this line.
Item 4	# CSR Line Calls Abandoned
Description	Number of calls weekly received into CSR Line during hours of operation that were abandoned (disconnected) by the caller or the system before being answered.
Item 5	% CSR Calls Abandoned
Description	Percent of CSR Line calls that are abandoned. The Formula is *# of Abandoned CSR calls [DIVIDED BY] # Number of total CSRcalls*
Item 6	Number of CSR calls resolved the first call
Description	Number of CSR Line calls that were resolved during the initial call.
Item 7	Percent of CSR Calls resolved during the first call.
Description	The formula is:# of calls resolved during the initial call [DIVIDED BY] #of total calls received on the CSR line.
Item 8	NF Line Number of Total Calls
Description	The total number (whole numbers only) of calls received by NF Line during hours of operation. This includes: • Inbound calls directly from an NF, (or provider, facility, or other entity that might have been misdirected to this line) • Transfers into the NF Line or other appropriate line • The member or other entity selects an option placing the member into the automatic call distribution (ACD) call queue.

Item 9	NF Lines Weekly Average Speed to Answer (ASA) Calls
Description	Amount of time reflected in seconds to complete the call on this line
Item 10	NF Line Weekly Average Handle Time (AHT) NF Calls
Description	Amount of time reflected in minutes and seconds to complete the call
Item 11	Total Number of Total Calls Abandoned Weekly on NF Line
Description	Number of calls received on NF Line during hours of operation that were abandoned/disconnected before being answered.
Item 12	Percent of Calls NF Abandoned
Description	Percent of NF Line calls that are abandoned. The Formula is *# of Abandoned NF calls [DIVIDED BY] # Number of total NF calls*
Item 13	Weekly Number of NF Line calls Resolved First Call
Description	Number of NF Line calls that were resolved during the initial call.
Item 14	Percent of NF Line Calls Resolved during the Initial Call
Description	The formula is *# of NF calls resolved during the initial call [DIVIDED BY] # of NF calls received.*
Item 15	QA Line Number of Total Calls
Description	The total number (whole numbers only) of calls received by QA Line during hours of operation. This includes: • Inbound calls directly from any entity to the QA Line • Transfers into the QA Line or other appropriate line
Item 16	QA Lines Weekly Average Speed to Answer (ASA) Calls
Description	Amount of time reflected in seconds to complete the call on this line
Item 17	QA Line Weekly Average Handle Time (AHT) NF Calls
Description	Amount of time reflected in minutes and seconds to complete the call
Item 18	Total Number of Total Calls Abandoned Weekly on QA Line
Description	Number of calls received on QA Line during hours of operation that were abandoned (disconnected) by the caller or the system before being answered.
Item 19	Percent of Calls Abandoned
Description	Percent of QA Line calls that are abandoned. The Formula is *# of Abandoned QA calls [DIVIDED BY] # Number of total QA calls*
Item 20	Weekly Number of QA Line calls Resolved First Call
Description	Number of QA Line calls that were resolved during the initial call.

Item 21	Percent of QA Line Calls Resolved during the Initial Call
Description	This is an auto-calculated field. The formula is: # of calls resolved during the initial call [DIVIDED BY] #of calls received.
Item 22	Facility Line Number of Total Calls
Description	The total number (whole numbers only) of calls received by Facility Line during hours of operation. This includes: • Inbound calls directly from any entity to the Facility Line • Transfers into the Facility Line or other appropriate line
Item 23	Facility Line Weekly Average Speed to Answer (ASA) Calls
Description	Amount of time reflected in seconds to complete the call on this line
Item 24	Amount of time reflected in seconds to complete the call on this line
Description	Amount of time reflected in seconds to complete the call on this line
Item 25	Total Number of Total Calls Abandoned Weekly on Facility Line
Description	Number of calls weekly received into Facility Line during hours of operation that were abandoned (disconnected) by the caller or the system before being answered.
Item 26	Percent of Calls Abandoned
Description	Percent of Facility Line calls that are abandoned. The Formula is # of Abandoned calls [DIVIDED BY] # Number of total calls
Item 27	Weekly Number of Facility Line calls Resolved First Call
Description	Number of Facility Line calls that were resolved during the initial call.
Item 28	Percent of Facility Line Calls Resolved during the Initial Call
Description	This is an auto-calculated field. The formula is: # of calls resolved during the initial call [DIVIDED BY] #of calls received.
Item 29	Where's My Ride (WMR) Line Number of Total Calls
Description	The total number (whole numbers only) of calls received by WMR Line during hours of operation. This includes: • Inbound calls directly from any entity to the WMR Line • Transfers into the WMR Line or other appropriate line
Item 30	WMR Lines Weekly Average Speed to Answer (ASA) Calls
Description	Number reflecting average speed, in seconds, for call center staff to answer.

Item 31	WMR Line Weekly Average Handle Time (AHT) NF Calls. This includes the amount of time the caller is on hold while awaiting resolution.
Description	Amount of time reflected in minutes and seconds to complete the call
Item 32	Total Number of Total Calls Abandoned Weekly on WMR Line
Description	Number of calls weekly received into WMR Line during hours of operation that were abandoned (disconnected) by the caller or the system before being answered.
Item 33	Percent of Calls Abandoned
Description	Percent of WMR Line calls that are abandoned. The Formula is # of Abandoned calls [DIVIDED BY] # Number of total calls
Item 34	Weekly Number of WMR Line calls Resolved First Call
Description	Number of WMR Line calls that were resolved during the initial call.
Item 35	Percent of WMR Line Calls Resolved during the Initial Call
Description	This is an auto-calculated field. The formula is: # of calls resolved during the initial call [DIVIDED BY] #of calls received.
Item 36	Provider Line Number of Total Calls
Description	The total number (whole numbers only) of calls received by Provider Line during hours of operation. This includes: • Inbound calls directly from any entity to the Provider Line • Transfers into the Provider Line or other appropriate line
Item 37	Provider Lines Weekly Average Speed to Answer (ASA) Calls
Description	Number reflecting average speed, in seconds, for call center staff to answer.
Item 38	Provider Line Weekly Average Handle Time (AHT) NF Calls
Description	Amount of time reflected in minutes and seconds to complete the call
Item 39	Total Number of Total Calls Abandoned Weekly on Provider Line
Description	Number of calls weekly received into Provider Line during hours of operation that were abandoned (disconnected) by the caller or the system before being answered.
Item 40	Percent of Calls Abandoned
Description	Percent of Provider Line calls that are abandoned. The Formula is

	# of Abandoned calls [DIVIDED BY] # Number of total calls
Item 41	Weekly Number of Provider Line calls Resolved First Call
Description	Number of Provider Line calls that were resolved during the initial call.
Item 42	Percent of Provider Line Calls Resolved during the Initial Call
Description	This is an auto-calculated field. The formula is: # of calls resolved during the initial call [DIVIDED BY] #of calls received.

Weekly HRM/MCA Report

General Report Description	
Purpose	To track HRM/MCA members will receive the highest priority for transportation to assure transport to and from their appointments.
Description & Definitions	The HRM/MCA Team oversees transportation services for all HRM & MCA members. The HRM/MCA team will work to identify a Preferred Provider and route and dispatch all trips for these members. An MCA member will remain on the MCA list until the following has occurred: • Three (3) consecutive trip events have occurred as planned. • Confirmation that each of the three (3) trips has occurred without incident (i.e. member was not late to their appointment, was not picked up late for the return trip, correct mobility was provided, etc.). • Approval of removal from the MCA list has been received from the NEMT Director.
Frequency	Weekly
Data Elements	
Item 1	NH Flag
Description	All members that are HRM/MCA that reside in a Nursing Home or live in "other" settings.
Item 2	Flag Type
Description	Describes whether the member is HRM, MCA or both
Item 3	Trip Leg Status
Description	Details whether the trip was canceled, dispatched, paid, pay pending, or denied
Item 4	Leg Count
Description	Details the number of trip legs that pertain to the particular category.
Item 5	Leg %
Description	The percentage of trips in that specific leg status versus the total amount.

Weekly Member No-Shows

General Report Description	
Purpose	To monitor the number of member no-shows.
Frequency	Weekly
Data Elements	
Item 1	Member Name
Description	Unduplicated Name of each member who had a no show for the experience period
Items 2	Member RID
Description	Member Medicaid Recipient ID
Item 3	Weekly no show count
Description	Number of times member was a no show for a ride during the experience period
Item 4	Total # Trips this period
Description	Total number of trips scheduled for a member for the experience period
Item 5	Member Education/Outreach
Description	Indicate if member outreach/education was completed this period

Network Development

General Report Description	
Purpose	To monitor the status of the provider network and assess network adequacy
Frequency	Weekly
Data Elements	
Item 1	Provider
Description	Name of any providers that have indicated an interest in providing NEMT transportation
Item 2	Initial Contact
Description	Date of Initial Contact
Item 3	Contract Type
Description	Type of Contract
Item 4	Garage
Description	Anticipated Garage County
Item 5	IHCP?
Description	Is Contact already IHCP
Item 6	Provider
Description	Name of Provider(s) in pre-credentialing process
Item 7	Initial Date of Contact
Description	Date when the initial contact was made
Item 8	Date Started Pre-Credentialing
Description	Date when the provider started the pre-credentialing process
Item 9	Contract Type
Description	Type of Contract
Item 10	Garage County
Description	Anticipated Garage County
Item 11	IHCP?
Description	Enter Y if the provider is an IHCP provider or N if not.
Item 12	Credentialing
Description	Name of provider(s) in credentialing process.

Item 13	Date Started credentialing
Description	Date when provider listed started credentialing process
Item 14	Activated?
Description	Enter Y if the provider is activated and N if it is not.
Item 15	Contract type
Description	Type of contract provider in credentialing will have
Item 16	Garage County
Description	Anticipated garage county
Item 17	IHCP?
Description	Is provider approved by IHCP
Item 18	Counties Served
Description	Counties provider listed expects to serve when active
Item 19	Amby Vehicles
Description	Number of Ambulatory Vehicles
Item 20	WC Vehicles
Description	Number of Wheelchair Vehicles
Item 21	Ambulances
Description	Number of Ambulances
Item 22	Providers Activated
Description	Name of provider(s) activated
Item 23	Date Started Credentialing
Description	Date when provider started credentialing process
Item 24	Date Activated
Description	Date when SET activated provider
Item 25	Contract Type
Description	Type of provider contract signed
Item 26	Garage County
Description	Garage County for the provider
Item 27	IHCP?
Description	Is Provider IHCP approved (must be yes for active provider)

Item 28	Counties Services
Description	Counties where provider will serve
Item 29	Amby Vehicles
Descriptions	Number of active ambulatory vehicles
Item 30	WC Vehicles
Description	Number of active wheelchair vehicles
Item 31	Ambulances
Description	Number of Ambulances to provide NEMT services
Item 32	Provider Deactivated
Description	Name of Provider(s) Deactivated
Item 33	Deactivation Date
Description	The date the provider was deactivated
Item 34	Garage County
Description	Garage county for the deactivated provider(s)
Item 35	Amby Vehicles
Description	Number of ambulatory vehicles deactivated
Item 36	WC Vehicles
Description	Number of Wheelchair Vehicles deactivated
Item 37	Ambulances
Description	Number of Ambulances deactivated for NEMT
Item 38	Counties Services
Description	Deactivated provider provided services in which counties
Item 39	Reason
Description	Reason for deactivation
Item 40	Trips past 30 days
Description	The trips the deactivated provider provided in the last 30 days
Item 41	Total active providers
Description	The total number of active providers in the network

Weekly Provider No-Shows

General Report Description	
Purpose	To monitor the volume of providers who fail to transport members with a scheduled ride due to a provider error or omission.
Frequency	Weekly
Data Elements	
Item 1	Provider Name
Description	Enter the name of the transportation provider who was a no-show.
Item 2	Provider LPI
Description	Enter the Provider ID number (LPI) for the provider who was a no-show.
Item 3	Total Number of No-Shows
Description	Enter the total number of provider no-shows for rides scheduled during the experience period.
Item 4	Total Number of Rides Assigned
Description	Enter the total number of rides assigned to the provider for the experience period.
Item 5	Provider No Show Rate
Description	This is a calculated field. The formula is *Total # of Provider No Shows for that specific provider [DIVIDED BY] Total # of Rides*

Weekly Sendbacks

General Report Description	
Purpose	To monitor the volume of sendbacks by providers
Frequency	Weekly
Data Elements	
Item 1	Provider Name
Description	Enter the provider name who sent 1 or more trips back during the experience period
Items 2	Total # Assigned Trips
Description	Enter the total number of trips the specific provider was assigned during the experience period
Item 3	# Send Backs by Provider
Description	Total # of Send backs by the specific provider during the experience period
Item 4	Number <= 48 hours
Description	Enter the number of trips that were sent back in less than or equal to 48 hours of the scheduled trip
Items 5	Percent <= 48 hours
Description	This is a calculated field. The formula is *number of trips sent back <= 48 hrs of trip divided by total trips sent back*
Item 6	Number > 48 hrs
Description	Enter the number of trips that were sent back with more than 48 hours of the scheduled trip.
Item 7	Percent > 48 hours
Description	This is a calculated field. The formula is *the number of send backs with more than 48 hours of scheduled trip divided by the total number of send backs.*
Item 8	Total percent sent back
Description	This is a calculated field. The formula *is the total number of send backs for that provider divided by the total number of trips assigned to that provider*

MONTHLY REPORTS

1. Claims Processing & Adjudication
2. Corrective Action Summary
3. Complaint Summary
4. Complaints Details
5. Incident Reports
6. Request & Scheduling
7. Safety & Compliance
8. Send Backs Summary
9. Regional Coverage & Gaps (*no template provided)*
10. Vehicles by County List
11. Vehicle Heat Map *(no template provided)*

Performance Dashboard

GENERAL REPORT DESCRIPTION	
Purpose	This is a running dashboard that overviews key performance metrics as well as tracks both contractual and legislative reporting requirements.
Legal Reference	FSSA/Southeastrans Inc Contract
Frequency	Monthly
DATA ELEMENTS	
Item 1	Total Gross Reservations
Description	The gross number of reservations (trip requests) made.
Item 2	Total Missed Trips
Description	The number of reservations that did not result in a trip for any reason.
Item 3	Total Denied
Description	The number of reservations denied for any reason.
Item 4	Auto-Routed %
Description	The percentage of reservations assigned via the broker's auto-routing system. *This is a performance metric.*
Item 5	Completed Tip Legs
Description	The number of trip legs (one-way transport) that were successfully completed.
Item 6	Full-filled Trip Rate
Description	The percentage of reservations that successfully were filled as scheduled. (Total Completed Trip Legs divided by the total trip legs reserved/requested X 100)
Item 7	Number of providers in the network.
Description	The unduplicated number of active transportation providers in the network on the last business day of the reporting period.
Item 8	Number of vehicles in the network
Description	The unduplicated number of active vehicles in the network on the last business day of the reporting period. Vehicles that serve multiple modality types should only be counted once.
Item 9	No provider assigned rate
Description	The percentage of missed trips that occurred because no provider was assigned to deliver the service. This includes trips that were sent-back and

	not re-assigned as initially reserved. (The formula for this is the number of missed trip legs due to no provider assigned divided by the total number of gross reservations/requested trip legs X 100) *This is a performance metric.*
Item 10	Number of calls received
Description	The total number of calls received via all customer service lines.
Item 11	Number of calls answered.
Description	The total number of calls answered by a live person via all customer service lines.
Item 12	Average wait time
Description	The average time in seconds a caller waited before speaking to a live person across all customer service lines
Item 13	Abandonment percentage
Description	The percentage of callers who hang up before speaking to a live person across all customer service lines. (Number of abandoned calls divided by total calls X 100) *This is a performance metric.*
Item 14	After-hours on-time call back
Description	The percentage of after-hours calls that are returned the following business day. *This is a performance metric.*
Item 15	1st Call resolution rate
Description	The percentage of all calls that are resolved (see definition) on the first call. *This is a performance metric.*
Items 16	Percentage of calls answered within 45 seconds.
Description	The percentage of all calls that are answered by a live person in 45 seconds or less. *This is a performance metric.*
Item 17	Percentage of calls answered within 60 seconds.
Description	The percentage of all calls that are answered by a live person in 60 seconds or less. *This is a performance metric.*
Item 18	Total number of complaints
Description	The gross number of all complaints. A complaint that is registered via multiple sources should be counted as a separate complaint.
Item 19	Total number of valid complaints
Description	The gross number of all valid (see definitions) complaints. A complaint that is registered via multiple sources should be counted as separate complaint.

Item 20	Total number of substantiated complaints.
Description	The gross number of valid complaints that after investigation were substantiated (see definitions) by SET staff
Item 21	On-time complaint closure rate
Description	The percentage of valid complaints that were investigated and resolved (see definitions) during the reporting period **and** within 15 business days regardless of when the complaint was filed. *This is a performance metric.*
Item 22	% of valid complaints on completed trips
Description	The percentage of valid complaints per completed trip calculated by dividing the number of valid complaints by the number completed trips in the reporting period. *This is a performance metric.*
Item 23	Claims submitted dollars
Description	The dollar amount (not paid amount) of claims submitted during the month reported, regardless when the trip occurred.
Item 24	# Total Claims Received
Description	The total number of clean claims received in any way (paper or electronic) during the month reported regardless when the trip occurred.
Items 25	# Clean claims Electronic
Description	The total number of clean claims received electronically during the month reported, regardless when the trip occurred.
Item 26	# Clean Claims Paper
Description	The total number of clean claims received via paper during the month reported, regardless when the trip occurred.
Item 27	Electronic claim Rate
Description	Number of Electronic Claims received during the month reported divided by the total number of claims received during the month reported X100. *This is a performance metric.*
Item 28	# of clean Electronic Claims Paid/Denied within 27 days
Description	The number of clean electronic claims that were received during the month reported that were paid within 21 days of receipt.
Item 29	% of Electronic Claims Paid/Denied within 21 days
Description	The percentage of clean Electronic claims that were received during the month reported that were paid within 21 days. (Number of electronic claims paid within 21 days divided by total electronic claims received during the month reported, X 100). *This is a performance metric.*

Item 30	# of Paper claims Paid/Denied within 30 days
Description	The number of clean paper claims that were received during the month reported that were paid within 30 days of receipt.
Item 31	% of paper claims paid/denied within 30 days
Description	The percentage of clean Paper claims that were received during the month reported that were paid within 30 days. (Number of clean paper claims paid within 30 days divided by total clean paper claims received during the month reported, X 100). *This is a performance metric.*
Item 32	Required Early Boarding
Description	The percentage of trips where a member was required to board prior to scheduled pick up time (does not include if a member wants to board the vehicle early) *This is a performance metric.*
Item 33	On Time Performance—Drop-off to Appointment
Description	The percentage trips that arrive to medical appointment on or before the scheduled time. *This is a performance metric.*
Item 34	On time performance-Leg B Pickup FROM appointment
Description	The percentage of trips where the member is picked up within an hour of notifying they are ready for pick up/or scheduled for pick up from the appointment. *This is a performance metric.*
Item 35	Missed Trips
Description	The total number of missed trips for any reason for the month reported.
Item 36	Overall % Missed Trips/Completed Trip
Description	The number of missed trips divided by the number of completed trips X 100. *This is a performance metric.*
Item 37	Member Late Trips
Description	The number of trips where the member was late
Item 38	Overall % Late Trips/Completed Trips
Description	
Item 39	Total Member Missed Trips and Late Trips
Description	
Item 40	Overall % late + Missed Trips/Completed Trips
Description	
Item 41	Member No-Shows
Description	The number of member no shows or if the member cancels at the door.

Item 42	% of Member No Shows per completed trip
Description	Number of Member No Shows divided by the number of completed trips X 100. *This is a performance metric.*
Item 43	Number of Vehicles Inspected
Description	The number of vehicles inspected during the month reported.
Item 44	Inspection Pass Rate
Description	# Vehicles inspected that passed inspection/# total vehicles inspected
Item 45	Number of spot inspections
Description	The number of spot inspections that occurred during the month reported.
Item 46	Spot Inspection Rate (% of total fleet)
Description	The number of spot inspections completed divided by the total number of vehicles in the fleet on the last day of the month X 100. *This is a performance metric.*
Item 47	Number of WC Securement Inspections
Description	The number of wheelchair securement inspections that were completed during the month reported. *This is a performance metric.*
Item 48	Providers meeting licensing & training
Description	The percentage of the providers that meet the licensing and training requirements. *This is a performance metric.*
Item 49	Total number of Accidents (Incidents) reported
Description	Total number of Accidents and Incidents reported during the month
Item 50	% of Trips with Accident
Description	
Item 51	Call Center Overall Satisfaction
Description	Based on the third-party survey, the score (percentage) for overall satisfaction with the call center.
Item 52	Transportation Overall Satisfaction
Description	Based on the third-party survey, the score (percentage) for overall satisfaction with the transportation providers.
Item 53	Total number of opened cases for fraud, waste and abuse
Description	The total number of cases newly opened during the month reported regarding possible fraud, waste and abuse.
Item 54	Total Number of Closed Cases

Description	Total number of closed possible fraud, waste and abuse cases that were closed during the month (some might have been opened in prior months)
Item 55	Ambulatory Trip Legs
Description	Total number of trip legs completed that were ambulatory for the month reported
Item 56	Wheelchair trip legs
Description	For the month reported, the total number of wheelchair trip legs that were completed.
Item 57	Ambulance Trip Legs
Description	For the month reported, the total number of ambulance trip legs that were completed
Item 58	Public Transit Trip Legs
Description	For the month reported, the total number of Public Trip legs that were completed.
Item 59	Mileage Reimbursement Trip Legs
Description	For the month reported, the total number of Mileage Reimbursement Trip Legs that were completed.
Item 60	Mileage Distribution Under 10 miles
Description	For the month reported, the number of trip legs where the distance was under 10 miles.
Item 61	Mileage Distribution Under 25 miles
Description	For the month reported, the number of trip legs where the distance was between 10 and 25 miles.
Item 62	Mileage Distribution Under 50 miles
Description	For the month reported, the number of trip legs where the distance was between 25 and less than 50 miles.
Item 63	Mileage Distribution over 50 miles
Description	For the month reported, the number of trip legs where the distance was more than 50 miles.

Claims Summary

GENERAL REPORT DESCRIPTION	
Purpose	To assess the Broker's claims processing productivity and timeliness in adjudicating clean provider claims.
Legal Reference	IC- 12-15-13 : Provider Payment; General
Frequency	Monthly
DATA ELEMENTS	
Item 1	Total Submitted Dollars (not paid amount)
Description	Enter the total submitted dollars for all CMS 1500 (professional) claims received during the reporting period. This is the total billed amount by the provider. This is not the amount paid by the Broker for services rendered.
Item 2	Clean Claims Received – Electronic
Description	The number of electronically submitted clean claims broken out by claim type CMS 1500 (professional), in-network and out-of-network. DO NOT count rejected claims nor replacement claims as received claims if the Broker can identify these coming into inventory.
Item 3	Clean Claims Received – Paper
Description	The number of submitted clean paper claims broken out by claim type CMS 1500 (professional), in-network and out-of-network. DO NOT count rejected claims or replacement claims as received claims if the Broker can identify these coming into inventory.
Item 4	Clean Claims Adjudicated - Paid On Time
Description	The number of adjudicated clean claims that the Broker paid on time during the month, by claim type CMS 1500 (professional), in-network and out-of-network. This number includes claims that were received and paid during the month as well as those paid that were received in previous months. *The Excel template auto-calculates a Paid On-Time Rate. Claims paid on time are those with a remittance date within 30 days of filing.
Item 5	Clean Claims Adjudicated - Paid Late
Description	The number of adjudicated clean claims that the Broker paid late during the month, by claim type CMS 1500 (professional), in-network and out-of-network. This should include adjudicated claims that were received during the month as well as prior month claims that were adjudicated in

	the reporting period. Claims paid late are those with a remittance date after 30 days from filing.
Item 6	Clean Claims Adjudicated – Denied
Description	The number of adjudicated clean claims that the Broker denied for payment during the month, by claim type CMS 1500 (professional), in-network and out-of-network. This should include all claims adjudicated regardless of the month received. *The Excel template auto-calculates a Denial Rate.
Item 7	Total Number of Claims Paid with Interest
Description	The total number of claims that the Broker paid with interest for all providers by claim type CMS 1500 (professional). Replacement claims should be included in this count. *Per IC 12-15-13 the Broker must pay interest on all clean claims paid late.*
Item 8	Total Dollar Amount of Interest Paid
Description	The total dollars in interest that the Broker paid to all providers by claim type CMS 1500 (professional). This should include interest paid on replacement claims.
Item 9	Claims Lag – Average Number of Days between the Last Date of Service on Claim and Broker's Receipt of Claim from Provider
Description	Indicate by claim type CMS 1500 (professional), in-network and out-of-network, the average number of calendar days between the last date of service listed on the claim and the date the Broker received the claim into the Broker's claims inventory management system.
Item 10	Claims Lag – Average Number of Days between Receipt Date of Claim by the Broker to Adjudication Date
Description	Indicate by claim type CMS 1500 (professional), in-network and out-of-network, the average number of calendar days between the date the Broker received the claim in its claims inventory management system and date the Broker adjudicated the claim [finalized a claim determination/ decision] in its claims system.
Item 11	Claims Lag – Average Number of Days from Adjudication Date to Payment (Remittance Advice) Date
Description	Indicate by claim type CMS 1500 (professional), in-network and out-of-network, the average number of calendar days between the date the Broker adjudicated the claim to the date the Broker generated remittance advice [i.e., payment date].
Item 12	Clean Claims Adjudicated and Submitted as Encounters to DXC

Description	The number of adjudicated clean claims submitted to DXC, by claim type CMS 1500 (professional), in-network and out-of-network.
Item 13	Clean Claims Accepted by DXC
Description	The number of adjudicated clean claims accepted by DXC claim type CMS 1500 (professional), in-network and out-of-network.
Item 14	Clean Claims Rejected by DXC
Description	The number of adjudicated clean claims rejected by DXC during the month, by claim type, CMS 1500 (professional), in-network and out-of-network.
Item 15	Acceptance Rate (calculated)
Description	This is a calculated field with two decimal spaces.
Items 16	Number of Clean Claims Adjudicated in 0-10 Days
	The number of claims from providers that were adjudicated and paid if applicable, by claim type CMS 1500 (professional). A claim should be counted in only one processing date span. The Broker should omit replacement (adjusted) claims from this data. Data should be reported as In-Network Paper Claims; In-Network Electronic Claims; Out-of-Network Paper Claims, and Out-of-Network Electronic claims.
Item 17	Number of Clean Claims Adjudicated in 11-21 Days
Description	The number of claims from providers that were adjudicated and paid if applicable, by claim type CMS 1500 (professional). A claim should be counted in only one processing date span. The Broker should omit replacement (adjusted) claims from this data. Data should be reported as In-Network Paper Claims; In-Network Electronic Claims; Out-of-Network Paper Claims, and Out-of-Network Electronic claims.
Item 18	Number of Clean Claims Adjudicated in 22-30 Days
Description	The number of claims from providers that were adjudicated and paid if applicable, by claim type CMS 1500 (professional). A claim should be counted in only one processing date span. The Broker should omit replacement (adjusted) claims from this data. Data should be reported as In-Network Paper Claims; In-Network Electronic Claims; Out-of-Network Paper Claims, and Out-of-Network Electronic claims.
Item 19	Number of Clean Claims Adjudicated in 31-60 Days
Description	The number of claims from providers that were adjudicated and paid if applicable, by claim type CMS 1500 (professional). A claim should be counted in only one processing date span. The Broker should omit

	replacement (adjusted) claims from this data. Data should be reported as In-Network Paper Claims; In-Network Electronic Claims; Out-of-Network Paper Claims, and Out-of-Network Electronic claims.
Item 20	Number of Clean Claims Adjudicated in 61-90 Days
Description	The number of claims from providers that were adjudicated and paid if applicable, by claim type CMS 1500 (professional). A claim should be counted in only one processing date span. The Broker should omit replacement (adjusted) claims from this data. Data should be reported as In-Network Paper Claims; In-Network Electronic Claims; Out-of-Network Paper Claims, and Out-of-Network Electronic claims.
Item 21	Number of Clean Claims Adjudicated in > 90 Days
Description	The number of claims from providers that were adjudicated and paid if applicable, by claim type CMS 1500 (professional). A claim should be counted in only one processing date span. The Broker should omit replacement (adjusted) claims from this data. Data should be reported as In-Network Paper Claims; In-Network Electronic Claims; Out-of-Network Paper Claims, and Out-of-Network Electronic claims.
Item 22	Total (Calculated)
Description	Total of all claims adjudicated for all time frames by category of submission (paper, electronic, in-network, out-of-network)
Item 23	Total on time
Description	Total number of claims paid on time (within 30 days of receipt) (should equal Item #4)
Item 24	Percentage on time
Description	Percentage of claims paid on time (within 30 days of receipt of clean claim). Calculated field: # paid on time divided by Total paid.
Items 25-34	Top Denial 10 denial reasons for claims
Description	Starting with the most frequent reason for denial for that reporting reason, ending with the 9th most frequent for item 33, the reason and the number of claims denied for that reason will be listed. The reason for the denial will be listed as well as the number of claims that were denied for that reason. The last reason (Item 34) is the remaining reasons for denial in one "bucket" labeled "other", and then the number of denials for those remaining reasons. If there are not at least 10 reasons for denials for that month, put N/A in the reason and leave the number blank.

Corrective Action

General Report Description	
Purpose	To monitor corrective action taken by the Broker against providers, drivers and/or vehicles; monitor Program Integrity Referrals to FSSA with regard to monitoring Fraud, Waste, and Abuse in the NEMT program.
Frequency	Monthly. The Corrective Action portion must be completed monthly, even if no corrective action was taken. The Program Integrity portion is not to be completed unless there is a referral to FSSA Program Integrity Unit.
Definitions	Corrective Action is defined as an activity or penalty that is take in response to non-compliance, incidents, fraud/waste, or other situations that great risk and/or misuse of services. Corrective Action may take the form of • Fines/Penalties • Temporary deactivation of Drivers, Vehicles and/or Providers • Permanent deactivation of Drivers, Vehicles and/or Providers • Training requirements • Policy or procedural changes • Other actions at the discretion of the Broker or FSSA
Legal References	42 CFR 455 - Program Integrity: Medicaid § 455.2 Program Integrity: Medicaid Definitions; § 455.13 Methods for identification, investigation, and referral; § 455.14 Preliminary investigations; § 455.17 Reporting requirements 18 U.S.C. 1347 Health care fraud 405 IAC 1 Medicaid Provider Services
Data Elements	
Item 1	Date of CA
Description	Enter the effective date of the corrective action. This data may be the date the Broker notified the provider of the action or it may be a past date if the action is retroactive due to the circumstances, i.e. Driver's License suspension.
Item 2	Corrective Action Cause

	Enter the situation that led to the need for corrective action. The following standard answer should be used **PI Finding**, **Non-Compliance** (which includes failed inspections), **Incident** (which includes accidents and moving violations, **Other** (explain in CA comments box)
Item 3	Provider Name
Description	Name of the transportation provider receiving the corrective action.
Item 4	Driver Name
Description	Enter the name of the driver(s) involved. Multiple drivers may be listed if connected to the same situation. However, they must be counted as separate individuals in the summary.
Item 5	Vehicle VIN
Description	Enter the VINs for all vehicles involved. Multiple vehicles may be listed if connected to the same situation. However, they must be counted as separately in the summary.
Item 6	Cause Reported to OMPP
Description	This is a Yes/No field and should affirm if the root situation was previously reported to OMPP
Item 7	Corrective Action Fine
Description	Enter the dollar amount of any assessed fine. If no fine was assessed, leave the amount at $0.00
Item 8	Driver Deactivated
Description	Enter **T** for temporary deactivation. Enter **P** for permanent deactivation
Item 9	Vehicle Deactivated
Description	Enter **T** for temporary deactivation. Enter **P** for permanent deactivation
Item 10	Provider Deactivated
Description	Enter **T** for temporary deactivation. Enter **P** for permanent deactivation
Item 11	Training Required (Y/N)
Description	This is a Yes/No
Item 12	Policy & Practice Change Required (Y/N)
Description	This is a Yes/No

Item13	Other Corrective Action Take
Description	Provide a very brief description of other corrective actions taken. Limit 10 words, i.e. monthly monitoring, weekly meetings w/broker
Item 14	Notes
Description	Use this field to document complaint numbers, explain 'other' root causes, and/or provide other critical information. Do not duplicate information provided on the incident or PI-related reports.
Item 15	Total CA count
Description	Enter the total number of Corrective Actions taken by root cause.
Item 16	Total Fines
Description	Enter the total amount of fines assessed by root cause
Item 17	Deactivated Drivers
Description	Enter the number of individual drivers deactivated either temporarily or permanently because of corrective action.
Item 18	Deactivated Vehicles
Description	Enter the number of individual vehicles deactivated either temporarily or permanently because of corrective action.
Item 19	Deactivated Providers
Description	Enter the number of individual providers deactivated either temporarily or permanently because of corrective action.
Item 20	Date Initiated
Description	ONLY COMPLETE IF REFERRAL WAS MADE TO FSSA Date that the audit or investigation began
Item 21	Provider Name
Description	ONLY COMPLETE IF REFERRAL WAS MADE TO FSSA The name of the Provider that this issue concerns.
Item 22	Driver(s) if Appropriate
Description	ONLY COMPLETE IF REFERRAL WAS MADE TO FSSA The name of the driver(s), if applicable, involved in this issue.
Item 23	Summary of Reason for Audit/Investigation
Description	ONLY COMPLETE IF REFERRAL WAS MADE TO FSSA Provide the reason that caused an audit or investigation to be done.

Item 24	Actions Taken
Description	ONLY COMPLETE IF REFERRAL WAS MADE TO FSSA Provide a detailed description of the action that was taken.
Item 25	Date Completed
Description	ONLY COMPLETE IF REFERRAL WAS MADE TO FSSA Date that the audit or investigation was completed. Once an issue has been completed, it should be dropped from the next month's report.
Item 26	Recoupment/Repayment Schedule
Description	ONLY COMPLETE IF REFERRAL WAS MADE TO FSSA Amount of any recoupment or repayment and the schedule for which it is to occur. Do not enter anything if the investigation is not complete.
Item 27	Projected Activity for Next Quarter
Description	ONLY COMPLETE IF REFERRAL WAS MADE TO FSSA Any projected activity that is anticipated to be done in the next quarter regarding this issue. All incomplete investigations should have an entry in this box.

Complaints and Appeals Summary

General Report Description	
Purpose	To monitor the number of complaints made.
Legal Reference	IC 12-15-30.5-4(a)(3)(E)
Frequency	Monthly
Data Elements	
Item 1	Complaints Received
Description	Number of complaints that were received in this reporting period.
Items 2	Complaints Acknowledged within 1 Business Day
Description	Number of complaints that were acknowledged as received within 1 business day in this reporting period.
Item 3	Percent of Complaints Acknowledged within 1 Business Day
Description	This is a calculated field. The formula is: # acknowledged w/in 1 business day [DIVIDED BY] total # of complaints.
Item 4	Complaints that were Investigated, Remediated, and Closed within 15 Business Days
Description	Number of complaints received in the reporting period that were investigated, remediated, and closed within 15 business days of receipt.
Item 5	Complaints Received that Were Not Investigated, Remediated, and Closed within 15 Business Day
Description	Number of complaints received in the reporting period that were not investigated, remediated and closed within 15 business days of receipt.
Item 6	Percent of Complaints Received that Were Not Investigated, Remediated, and Closed within 15 Business Days of Receipt
Description	This is a calculated field. The formula is: # received not investigated, remediated, and closed within 15 business days of receipt [DIVIDED BY] total # received this reporting period.
Item 7	Appeals Received
Description	Number of appeals that were received in this reporting period.
Items 8	Appeals Acknowledged within 1 Business Day
Description	Number of appeals that were acknowledged as received within 1 business day in this reporting period.

Item 9	Percent of Appeals Acknowledged within 1 Business Day
Description	This is a calculated field. The formula is: # acknowledged w/in 1 business day [DIVIDED BY] total # of appeals.
Item 10	Appeals that were Investigated, Remediated, and Closed within 15 Business Days
Description	Number of appeals received in the reporting period that were investigated, remediated, and closed within 15 business days of receipt.
Item 11	Appeals Received that Were Not Investigated, Remediated, and Closed within 15 Business Day
Description	Number of appeals received in the reporting period that were not investigated, remediated, and closed within 15 business days of receipt.
Item 12	Percent of Appeals Received that Were Not Investigated, Remediated, and Closed within 15 Business Days of Receipt
Description	This is a calculated field. The formula is: # received not investigated, remediated, and closed within 15 business days of receipt [DIVIDED BY] total # appeals received this reporting period.
Item 13	Complaint Type
Description	This column reflects all complaint types possible
Item 14	To Appointment
Description	Number of complaints related to A Leg trips for the reporting period.
Item 15	From Appointment
Description	Number of complaints related to B Leg trips for the reporting period
Items 16	Grand Total (row)
Description	Enter the total of item 2 plus item 3 for each row.
Item 17	Grand Total (column)
Description	Enter the total of each column.

Complaint Details

General Report Description	
Purpose	To monitor the volume and timely resolution of valid complaints submitted to the Broker.
Legal Reference	IC 12-15-30.5-4 (a)(1)(D)
Frequency	Monthly
Data Elements	
Item 1	Complaint Number
Description	Broker assigned ID for the complaint. Can be numeric or alpha-numeric
Item 2	Member Name
Description	The legal name of the member who filed the complaint or on whose behalf the complaint was filed.
Item 3	Member ID (RID)
Description	Member's Medicaid member ID (RID).
Item 4	Trip Date
Description	Enter the date of the trip that is the subject of the complaint.
Item 5	Complainant Name
Description	Enter the name of the person who filed the complaint.
Item 6	Complainant Relationship
Description	Choose the relationship of the complainant to the member (self, family, friend/advocate, nursing facility staff, dialysis staff, medical provider, other)
Item 7	Date Complaint Received
Description	Enter the date that the complaint was received.
Item 8	Complaint Received Via
Description	How the complaint was filed (QA Line, Web, Legislative, IBM, FSSA, Other)
Item 9	Complaint Category
Description	Complaint category as listed in the Qualifications/Definitions, above.
Item 10	Complaint Details
Description	Narrative description of the complaint. Do not paraphrase for the member.

Item 11	Name of Transportation Provider
Description	Enter the name of the Transportation Provider.
Item 12	Provider Response
Description	Enter the response to the complaint given by the transportation provider.
Item 13	Findings
Description	Enter the Broker's findings about the complaint upon completing the investigation of the complaint.
Item 14	Substantiated?
Description	Enter Y if the member's complaint was substantiated and N if it was not.
Item 15	SET Action
Description	Enter the action that has been taken or will be taken by Southeastrans based on the findings. This should not be the same as the findings.
Item 16	Date Resolved
Description	Enter the date that the complaint was resolved. The term "resolved" means that an answer or solution has been found regarding the member's grievance; therefore, no further action is needed.

Incident and Accident Reports

General Report Description	
Purpose	To monitor incidents, including but not limited to accidents and moving violations, involving drivers or Medicaid members.
Frequency	Monthly. This report must be filed even if no incidents occurred in the period
Definitions	**Incident** – Any situation in which there is potential to harm the member, violate local driving laws, and/or create an otherwise unsafe transportation experience. **Confrontation** – An incident that includes a verbal and/or physical confrontation between the driver and any of the following a member, a member's representative, medical provider staff, nursing facility staff. **Accident** – An incident that relates to the vehicle and occurs while the member is boarding, riding in, or exiting the provider's vehicle. The accident may or may not result in injury to the member and/or driver. Other vehicles may or may not be involved. **Moving Violation** – An incident involving the driver being stopped by law enforcement for violating any current Indiana driving laws.
Additional Requirements	Any accident resulting in driver or passenger injury or fatality while services were provided to a member must be reported within 1 business day to FSSA from the time the Broker is notified. The Broker shall file a written incident report with FSSA within ten (10) business days being notified of the incident. This report may follow the Broker's preferred format and is in addition to this summary report. If applicable, a police report is also required as supporting documentation. The Broker shall maintain copies of any associated police reports in the files of both the vehicle and the driver involved in the accident. The Broker and will cooperate with FSSA and law enforcement during any ensuing investigation or legal proceedings.
Data Elements	
Item 1	Date of Incident

Description	Enter the date the incident occurred.
Item 2	Type of Incident
	Choose one of the following. If an incident resulted in multiple issues, then select the highest issue type. Incident= low, Moving Violation = Middle, Accident = Highest
Item 3	Member First Name
Description	Legal first name of the member
Item 4	Member Last Name
Description	Legal last name of the member
Item 5	Rid#
Description	The member's Medicaid ID number
Item 6	Provider Name
Description	Name of the transportation provider assigned to the trip
Item 7	Driver Name
Description	Name of the NEMT driver involved. Do not include names of non-NEMT drivers and/or third parties in this field.
Item 8	Injury Y/N
Description	Dropdown menu options include None Member, Driver, 3rd Party, Multiple
Item 9	Law Enforcement Involved
Description	If Yes, enter the full name of the responding Law Enforcement Agency or 1st Responder, i.e. Indianapolis Metro Police, do not abbreviate the city or county name. If No, enter **N/A**
Item 10	Police Report Number
Description	If yes, enter the corresponding Police report ID. If no, enter **N/A**
Item 11	Date Reported to Broker Reported
Description	Enter the date the Broker was notified.

Item 12	Reported Timely Y/N?
Description	Select Yes or No to indicate if the provider met the corresponding reporting timeline.
Item13	Resolved Y/N?
Description	Select Yes or No to indicate if the incident is ongoing due to investigation, medical treatment or legal reasons
Item 14	Corrective Action
Description	This is a Yes/No field. Related details should be tracked on the Corrective Action Summary Report (MO-SET6).
Item 15	Incident Summary
Description	Summary of the incident in 150 words or less. DO NOT SAY "See Incident Report" or "See Police Report"
Item 16 – Item 22	Incident Summary Counts
Description	Enter the total number of occurrences in the reporting period for each field. Duplicate counting is allowable in all fields except the Total Incident field. For example, a single incident might have involved an accident, moving violation, and 2 injuries.

Request & Scheduling

General Report Description	
Purpose	To report out on the statuses of trips requested and scheduled, trip performance, missed trips, and modality. These are for requests only for the month reported; and those that are scheduled to occur during the month reported, those missed (cancelled) and completed (fulfilled) during the month reported.
Frequency Date	Monthly
Data Elements	
Item 1	**Status: Cancellation Failed**
Description	Attempt to cancel not successful
Item 2	**Status: Cancelled**
Description	Trip was Cancelled for any reason
Item 3	**Status: Denied**
Description	Trip was denied when submitted
Item 4	**Status: Dispatched**
Description	Leg is assigned and sent to the provider successfully
Item 5	**Incomplete**
Description	Leg was incomplete as member not home or canceled at the door.
Item 6	**Paid**
Description	Claim was submitted and in paid status
Item 7	**PayDenied**
Description	Claim was submitted and denial was sent.
Item 8	**Unassigned**
Description	A provider could not be found to take the trip
Item 9	**Requests**
Description	# Requests in each listed status
Item 10	**Scheduled**
Description	# Requests scheduled for each status
Item 11	**% Scheduled**
Description	The percentage of requests that were scheduled

Item 12	**Fulfilled**
Description	The number of requests in each status category that were fulfilled
Item 13	**% Fulfilled**
Description	The overall percentage of Requests that were fulfilled
Item 14	Trip Not Provided
Description	Reason listing for trip not provided
Item 15	To appt Legs
Description	Missed trip on way to appointment
Item 16	From Appt Legs
Description	Trips missed when being picked up from appointment
Item 17	Grand Total
Description	Total of missed trips (regardless of trip leg) for each reason
Item 18	Percent of scheduled rides
Description	Percent of each category of missed trip of all rides scheduled for the time period
Item 19-24	Request Details by Type
Description	In column K, enter the number of authorized requests for each type In column L, enter the number of requests that were subsequently canceled. In column M, enter the number of requests that were denied. Column N is a calculated field that totals of columns D, E, and F.
Item 25	Totals
Description	These are calculated fields. The formula is the total of items #1 through #6 for each column category.
Item 26	Trips for Substance Abuse
Description	In column K, enter the number of authorized requests for trips for substance abuse treatment. In column L, enter the number of requests that were subsequently canceled. In column M, enter the number of trips for substance abuse that were denied. Column N is a calculated field that totals of columns K, L, and M.
Item 27	Trips for Pharmacy Services Only
Description	In column K, enter the number of authorized requests for trips solely for pharmacy services. In column L,enter the number of requests that were subsequently canceled.

	In column M, enter the number of requests that were denied. Column N is a calculated field that totals of columns K, L, and M.
Item 28	Repeat Riders
Description	Enter the number of riders who have had 1 reservation or more in the experience period.
Item 29	New Riders
Description	Enter the number of unduplicated new riders. A new rider is one who has not used NEMT through the Broker for the last 3 months.
Item 30	On-time arrival at appointment
Description	In column K, enter the number of arrival trips. In column L, enter the number of trips where the member **did not arrive on time** for the scheduled appointment. This includes trips that were delayed do travel/road conditions. *Do not include trips where the Member is responsible for a delay due to tardiness or failure to appear for a pick-up.* Column M is a calculated field that is a percentage (out to two decimal points) of arrival trips that were NOT on time. Column N is a calculated field that is the percentage (out to two decimal points) of arrival trips that were on time.
Item 31	Return Pick-up Within 1 Hour
Description	In column K, enter the number of authorized return trips. In column L, enter the number of trips where the member **was not** picked up/boarded within 1 hour of notification to the Contractor. Column M is a calculated field that Is the percentage (out to two decimal points) of return trips that were NOT on time Column N is a calculated field that is the percentage (out to two decimal points) of return trips that were on time.
Item 32	Missed trips by member in Own Home
Description	Column C should have the number of missed trips for members who live in their own home going to an appointment; Column D should have missed trips for members living in own home coming from an appointment; Column E should have the Grand Total of missed appointments for members living in own home, and Column F should have the percent of missed trips for members living in own home compared to all scheduled rides for members living in own home.
Item 33	Missed trips by members in Nursing Facilities/Assisted Living
Description	Column C should have the number of missed trips for members who live

	in NF or AL going to an appointment; Column D should have missed trips for members living in NF or AL coming from an appointment; Column E should have the Grand Total of missed appointments for members living in NF or AL, and Column F should have the percent of missed trips for members living in NF or AL compared to all scheduled rides for members living NF or AL settings.
Item 34	Missed trips by members residing in hospital/rehabilitation facility
	Column C should have the number of missed trips for members who live in hospital/rehabilitation facility going to an appointment; Column D should have missed trips for members living in hospital or rehabilitation facility coming from an appointment; Column E should have the Grand Total of missed appointments for members living in hospital or rehabilitation facility, and Column F should have the percent of missed trips for members living in hospital or rehabilitation facility compared to all scheduled rides for members living NF or AL settings.
Item 35	Missed trips for members residing in other residential facilities
	Column C should have the number of missed trips for members who live in other residential facilities going to an appointment; Column D should have missed trips for members living in other residential facilities coming from an appointment; Column E should have the Grand Total of missed appointments for members living in other residential facilities, and Column F should have the percent of missed trips for members living in other residential facilities compared to all scheduled rides for members living NF or AL settings.
Item 36 and more if needed	Missed trips for members residing in "other" category (list below)
Description	Column C should have the number of missed trips for members who live in "other" settings (hotels, homeless camps, etc.) going to an appointment; Column D should have missed trips for members living in "other" settings coming from an appointment; Column E should have the Grand Total of missed appointments for members living in "other" settings, and Column F should have the percent of missed trips for members living in "other" settings compared to all scheduled rides for members living NF or AL settings.

Safety & Compliance

General Report Description	
Purpose	To monitor non-compliant vehicles and drivers and the number of repeat offenses.
Frequency	Monthly
Data Elements	
Item 1	Provider Name
Description	Name of the person/company providing NEMT services
Item 2	Vehicle Inspections Conducted
Description	The total number of vehicle inspections conducted in the experience period.
Item 3	Compliant Vehicle
Description	Total number of vehicles found to be in compliance.
Item 4	Non-compliant Vehicles – 1st Offence
Description	The number of vehicles found to be non-compliant for the first time.
Item 5	Non-Compliant Vehicles – Repeat Offence
Description	Number of vehicles found to be non-compliant for the 2nd or more times in the history of the vehicle's use.
Item 6	Driver Inspections
Description	The total number of driver inspections done in the reporting period.
Item 7	Compliant Drivers
Description	Total number of drivers found to be in compliance.
Item 8	Non-compliant Drivers – 1st Offence
Description	The number of drivers found to be non-compliant for the first time.
Item 9	Non-Compliant Drivers – Repeat Offence
Description	Number of drivers found to be non-compliant for the 2nd or more times in the history of the driver's service.

Send Backs Summary

GENERAL REPORT DESCRIPTION	
Purpose	To monitor the volume of trips declined by the transportation provider and % sent back less than 48 hours from the scheduled trip.
Legal Reference	SEA 480
Frequency	Monthly
DATA ELEMENTS	
Item 1	Total # Assigned trips
Description	Total number of assigned trips for the experience period
Item 2	Total # Send backs by providers
Descriptions	Total number of trips that all providers sent back
Item 3	Total % assigned trips sent back
Description	The percentage of total trips that were assigned that were sent back, either "timely" or "late"
Item 4	# Late sendbacks
Description	Number of trips sent back to the broker 48 hours or less (<=48 hours) from the scheduled trip time, where the transportation provider declined to provide the service for any reason
Item 5	Percent late sendback
Description	The percent of total send backs that were sent back in less than or equal to 48 hours of scheduled trip
Item 6	# Successfully re-assigned
Description	The number of late sendbacks (<= 48 hours) that were successfully re-assigned to another provider such that the trip was completed.
Item 7	% late sendbacks successfully re-assigned
Description	The percentage of late sendbacks (<=48 hours) that were successfully reassigned such that the trip was completed.
Item 8	Number timely sendbacks
Description	Number of trips sent back to the broker more than 48 hours before the

	scheduled trip time, where the transportation provider declined to provide the service for any reason
Item 9	Percent timely sendbacks
Description	The percent of sendbacks that were sent back with more than 48 hours of scheduled trip time
Item 10	# Timely sendbacks successfully reassigned
Description	The number of timely sendbacks (> 48 hours) that were successfully re-assigned to another provider such that the trip was completed.
Item 11	% timely sendbacks successfully re-assigned
Description	The percentage of timely sendbacks (>48 hours) that were successfully reassigned such that the trip was completed.

Vehicles by County List

GENERAL REPORT DESCRIPTION	
Purpose	To monitor the volume of available vehicles by county, provide a count of vehicles by type serving each county, and identify counties that lack access to particular services or vehicle types
Legal Reference	SEA 480
Frequency	Monthly
Description & Definitions	In accordance with Indiana Code, this report is to be produced as a listing by county. The data elements listed below must be incorporated into the listing. It is mutually understood that vehicles may serve multiple counties and thus the data will include duplicate counts.
Data Elements	
Item 1	Title & Reporting Period
Description	A clear, consistent title must be centered on the top of the page and must include the reporting month and calendar year.
Item 2	County Names
Description	Full County names are to be included alphabetically, vertically on the listing.
Item 3	Ambulatory
Description	The number of ambulatory vehicles serving each county during the reporting period shall be listed in this column.
Items 4	Ambulatory/Wheelchair
Description	The number of ambulatory/wheelchair vehicles serving each county during the reporting period shall be listed in this column.
Item 5	Ambulatory/Wheelchair/Stretcher
Description	The number of ambulatory/wheelchair/stretcher vehicles serving each county during the reporting period shall be listed in this column.
Item 6	Basic Life Support
Description	The number of stretcher vehicles providing basic life support serving each county during the reporting period shall be listed in this column.
Items 7	**Non-Contracted**

Description	The number of non-contracted vehicles serving each county during the reporting period shall be listed in this column.
Item 8	**Stretcher Van**
Description	The number of stretcher van vehicles serving each county during the reporting period shall be listed in this column.
Item 9	**Wheelchair Lift Van**
Description	The number of wheelchair lift van vehicles serving each county during the reporting period shall be listed in this column.
Item 10	**Total**
Description	The total number of vehicles of all types serving each county during the reporting period shall be listed in this column.

Regional Coverage & Gaps

General Report Description	
Purpose	To track the number of vehicles used in each of the States 10 Regions and identify any gaps in service by Region.
Frequency Date	Monthly
Additional Details	This report is to be completed in the format SET prefers to use (word, Excel, combinations, etc.)
Data Elements	
Item 1	**This report should review all regions by trip requests by modality, and determine network adequacy.** • **All relevant data should be included, for example, if a region has a high percentage of missed wheelchair trips, how many unique members does that affect, and what is SET doing to address the issues.** • **All regions should be discussed, but it is expected that regions with the more significant challenges and current or expected impacts on the network should have more developed discussion.** • **This report should also address how ongoing issues regarding the regional network adequacy are being addressed, and to explain why certain options are not being used (such as Lyft, gas reimbursement, etc.) more in the regions.** • **If a region had a particular challenge in a past report, it is expected that an update of the past issue will be discussed here.** • **This is a good place to discuss successes as well, such as how network issues have been addressed, and perhaps bring these solutions to other regions.** • **This report should also report on recruitment strategies for new providers/drivers to enhance the network.**

Vehicles by County Map (MO-VBCM)

GENERAL REPORT DESCRIPTION	
Purpose	To monitor the volume of available vehicles by county, provide a count of vehicles by type serving each county, and identify counties that lack access to particular services or vehicle types
Legal Reference	SEA 480
Frequency	Monthly
Description & Definitions	In accordance with Indiana Code, this report is to be produced as a heat map of the state of Indiana. The data elements listed below must be incorporated into the map. It is accepted that a vehicle may serve multiple counties and thus the map gradation and counts will have duplicate counts To ensure consistent branding, please use the following FSSA branding standards as a guide when developing the map. • FSSA's primary Green should be used as the base color. The RBG code for FSSA Green is Pantone 348C or RBG: 0, 140, 91 • All text should be in black ink unless the background is a dark color in which white text may be used. The preferred font is Times New Roman.
Data Elements	
Item 1	Map Title & Reporting Period
Description	A clear, consistent title must be centered on the top of the page and must include the reporting month and calendar year.
Item 2	County Names
Description	Full County names are to be included on the map
Item 3	Detailed Legend/Key
Description	A detailed legend/key is to be included in the bottom right corner of the page. The legend must include a title, explain the graduation and symbols used
Items 4	County Color Gradation
Description	Color gradation should be applied to show vehicle volume in the county. The lowest volume shall be indicated by the lightest coloring and the highest volume shall be indicated by the darkest color option.
Item 5	County Counts by Type

Description	Under the county name, the count of vehicles by serving the county should be listed as follows. See item 6 for information related to Zero counts. Total Count = Bold # Ambulance = A:# Ambulance w/Wheel Chair = AW: # Wheel Chair Van = WC: # EMS = E: #
Items 6	**No Vehicles of Type in Service**
Description	If a county lacks any type of vehicle, the count above should be list as Zero or marked (-) for null **and** the following symbol shall be added under the county name Ambulance = ^ Ambulance w/Wheel Chair = ≠ Wheel Chair Van = WC: * EMS = E: »
Item 7	**No County Based Vehicles**
Description	If a county has access to services, but none of the vehicles are locally based, then the county shall be filled with both the respective color and diagonal cross lines.
Item 8	**Data Source Reference**
Description	The text “Data Source” followed by a reference to the original data source shall be placed on the bottom center or right corner of the map.

ANNUAL, QUARTERLY & AD-HOC REPORTS

1. Active Vehicle Listing
2. Key Staff
3. Program Integrity Report & Plan

Active Vehicle Listing

General Report Description	
Purpose	To monitor the quantity and types of vehicles actively available to transport members and ensure compliance standards are met.
Frequency	Annual and ad-hoc by OMPP request
Data Elements	
Item 1	Provider Name
Description	Name of the person/company providing NEMT services
Item 2	Type of Vehicle
Description	Type of vehicle, i.e. CAS (regular) vehicle, NAS (wheelchair accessible vehicle) or stretcher accessible vehicle. Each vehicle must be listed separately.
Item 3	Passenger Capacity
Description	Total number of passengers, not including the driver, who can be transported in this vehicle. Enter a whole number.
Item 4	Vehicle Identification Number (VIN)
Description	The manufacturer's assigned Vehicle Identification Number (VIN).
Item 5	Vehicle License Plate Number
Description	The vehicle's license plate number.
Item 6	Vehicle Manufacturer
Description	The name of the company that manufactured the vehicle.
Item 7	Model
Description	Enter the name and/or model number of the vehicle.
Item 8	Vehicle Year
Description	The four-digit year the vehicle was manufactured.
Item 9	Last inspection Date
Description	Enter the last date the vehicle was inspected.
Item 10	Did Vehicle Pass Inspection
Description	If the vehicle failed any portion of the inspection, it must be marked No.

Key Staff

General Report Description	
Purpose	To confirm the Broker is appropriately staffed when key staff vacancies occur
Frequency	Annual and Ad-Hoc within 2 weeks of any key staff changes.
Additional Requirements	The Broker must also report to FSSA within 5 business days of receiving notice to terminate employment or 5 days before the vacancy, whichever is earlier. Such notice should be sent to the NEMT1@fsssa.in.gov email box. Data elements for this report should reflect counts on the last business day of the reporting period.
Data Elements	
Item 1	Key staff position
Description	Identify the Broker's vacant and interim key staff position from those listed here. If all key staff positions are filled, insert "NONE" in this field Key staff includes: • Chief Executive Officer (President/CEO/ED) • Chief Financial Officer • Indiana State Director • Indiana Quality Assurance Manager • Provider Services Manager • Data Compliance Manager • Claims Manager • Program Integrity Manager Other Staff includes all others working on the State of Indiana Contract: • Customer Service Call Center • Quality Assurance • Provider Relations • QRV Drivers • Claims • Finance/Accounting • Other (please define)
Item 2	Staff Name

Description	Enter the first and last name of the individual vacating the position.
Item 3	Title
Description	The position title left vacant or being filled on an interim basis.
Item 4	Plan for Covering Vacancy in the Interim
Description	Describe how the coverage of all duties will be managed in the interim.
Item 5	Contact Info (Email and Phone)
Description	Provide the full name, email, and telephone number for the contact person who will be responsible for overseeing the duties in the interim.
Item 6	Plan for Filling the Vacancy
Description	Describe the hiring process, timeline, and target date for filling the vacancy.
Item 7	Status
Description	If the position remains vacant for a duration that extends to a new reporting period, provide an update to the report as to progress, revised target dates, or changes to the staffing plan.
Item 8	Total FTE Count
Description	Total FTE Count – a count of the total number of FTEs working on the State of Indiana's business. If you have staff splitting time between SET customers, only the time spent on the State of Indiana business may be counted here.
Item 9	Total FTE Count in Indiana
	Of the total number of FTEs working on the State of Indiana's business, please identify the FTE count that is physically located in the State of Indiana.

Annual Program Integrity Plan Report

General Report Description	
Purpose	To monitor and evaluate the Broker's plan and efforts to address program integrity (PI). The plan will include a detailed description of the planned activities to identify, investigate, and resolve fraud, waste, and abuse issues of Broker providers, vendors, and subcontractors.
Legal References	42 CFR 455 - Program Integrity: Medicaid § 455.2 Program Integrity: Medicaid Definitions; § 455.13 Methods for identification, investigation, and referral; § 455.14 Preliminary investigations; § 455.17 Reporting requirements 18 U.S.C. 1347 Health care fraud 405 IAC 1 Medicaid Provider Services
Description & Definitions	The Annual Program Integrity Plan shall consist of two parts, 1.) the Broker's compliance plan and contain a prospective plan, and, 2.) a retrospective evaluation of prior year's activities. Details on each part are listed below. The prospective plan and retrospective evaluation may be a combined document if the report clearly separates the required material. The plan should be submitted in MS Word, MS Excel, or PDF format and follow all submission and naming rules. **Annual Plan (Prospective):** The report includes the mandatory requirements for the prospective goals and a detailed description of the planned activities, along with documentation of the routine methods for ongoing referrals and Broker initiatives that support program integrity compliance. The PI Plan should contain information specific to Indiana and contain each of the elements listed below. **Annual Evaluation (Retrospective)**: In the annual evaluation the Broker must review its PI plan and provide OMPP with the final status of goals previously set. The retrospective evaluation is due to OMPP by January 31 of each calendar year.
Frequency	Annual. Upon request by the OMPP, the Broker may be asked for quarterly or more frequent updates regarding the Broker's PI efforts and/or those related to a specific provider/vendor/subcontractor

DATA ELEMENTS	
Element 1	Policies
Description	Establishing and maintaining written policies for identification, investigation, and resolution of waste fraud and abuse issues of Broker providers, vendor, and subcontractors (including but not limited to Pharmacy Benefits Managers, vision, transportation, dental and Broker itself
Element 2	Standards of Conduct
Description	Standards of conduct and commitment to comply with all applicable state and federal standards
Element 3	Compliance Body
Description	Designation of a Special Investigation Unit Manager, a Compliance Officer, and a Compliance Committee
Element 4	Compliance Meetings with OMPP
Description	Documentation that the Compliance Officer and SIU Manager shall meet with OMPP at a minimum of quarterly.
Element 5	Compliance Training Schedule
Description	Type and frequency of training and education for the SIU Manager, compliance officer, and employees provided to detect fraud.
Element 6	Compliance Training Statement of Understanding
Description	Training must be annual and address False Claims Act, Indiana laws and requirements government Medicaid reimbursement and utilization of services, changes in rules, and other federal and state laws governing Medicaid provider participation and payment as directed by the CMS and FSSA.
Element 7	Risk Assessment
Description	A risk assessment of the Broker's various fraud and abuse/program integrity processes. The Broker shall inform OMPP of such action and provide details of such financial action on the monthly PI report. The assessment shall also include a listing of the Brokers' top three vulnerable areas and shall outline action plans mitigating such risks.
Element 8	Organizational Chart
Description	Organizational chart and communication plan highlighting lines of communication between the Special Investigations Unit Manager, Compliance Officer, and all compliance-related employees.
Element 9	Internal Monitoring & Auditing

Description	Description of plan for internal monitoring and auditing
Element 10	Program Integrity Plan
Description	Descriptions of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to a list of: • Goals, objectives and planned activities for the upcoming year • Automated pre-payment claims edits • Automated post-payment claims edits • Types of desk audit on post-processing review of claims • Reports for provider profiling and credentialing used to aid program and payment integrity reviews • Surveillance and/or utilization management protocols used to safeguard against unnecessary/inappropriate use of services • Provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials • References in provider and member material regarding fraud abuse referrals • Provisions for the confidential reporting of PI Plan violations to the designated person • Provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance reports • Provisions ensuring that the identities of individuals reporting violations of the Broker are reported and that there is no retaliation against such persons • Detailed internal procedures for officers, directors, and staff for detecting and reporting potential fraud and abuse violations • Reporting requirements – of any confirmed or suspected provider fraud and abuse under state or federal law to OMPP. • Retaliation – assurances that no individual who reports potential violations or suspected fraud and abuse is retaliated against • Site visits – policies and procedures for announced and unannounced site visits and field audits to providers defined as high risk (including but not limited to providers with abnormally high or low sendback rates, providers who submit paper logs) to ensure services are rendered and billed correctly • Response to detected offenses and development of corrective action initiatives.