EXHIBIT E
PROVIDER CAPACITY REPORT

A. REQUIREMENTS:

Contractor shall submit a Certified Provider Capacity Report and a Publicly Funded Program Involvement Status Report to the Division of Medical Assistance Programs (DMAP) with specific information about each of Contractor's Providers.

The Provider Capacity Report shall include data for each variable name appearing on the table below. To be in compliance with this requirement and that of Exhibit G, Contractor shall not omit the required information from the table below for any Participating Provider on the Provider panel. Providers include physicians (Primary Care Physicians (PCP) and specialists), dentists, hospitals, hospices, laboratories, Extended Care Facilities, DME Participating Providers, County Health Programs, Rural Health Centers, Federally Qualified Health Centers and any other Participating Provider, as defined in this Contract, with which Contractor has a subcontract. If a Participating Provider has more than one practice address, submit a separate record for each practice address of the Participating Provider.

For the purposes of this exhibit related to Credential Verification (Data Element #15 listed in the table below) Contractor shall refer to Contract Section 5(Y) and OAR 410-141-0120, pursuant to 42CFR438.214.

B. FILING REQUIREMENTS:

Contractor shall submit to DMAP a Certified Provider Capacity Report containing information about each Provider on their Provider panel as of January 1st (submit reports to DMAP by March 31st) of each year that this Contract is in effect. Contractor shall submit supplemental reports as directed by DMAP any time there has been a Material Change in Contractor's operations that would affect capacity or services, including (1) changes in services, benefits, service area or payments or (2) enrollment of a new population to Contractor. Contractor shall submit supplemental reports during the year, if requested by DMAP.

Contractor shall submit Form E1, certifying to the accuracy, completeness, and truthfulness of the information in the Provider Capacity Report, by fax to the number below.

Contractor shall submit to DMAP the Provider Capacity Report in an electronic format which has been approved by DMAP via e-mail by contacting your designated Prepaid Health Plan Coordinator (PHPC) or designee or by mailing a disk or compact disk (CD) containing the required information, as specified in subsection (C) below**,** to the following address:

Prepaid Health Plan Coordinator
Division of Medical Assistance Programs
Delivery Systems Unit
500 Summer Street NE, E-35
Salem, OR 97301-1077
Fax: (503) 947-5221

A Provider Capacity Report that is not certified or that does not contain all of the data elements specified

in subsection (C) below shall not be accepted by DMAP, and Contractor must submit a corrected Provider Capacity Report as directed by DMAP's designated Prepaid Health Plan Coordinator or designee.

DMAP will review the Provider Capacity Report and communicate preliminary findings to Contractor within 30 business days of receipt. If errors or omissions are found DMAP will communicate detailed findings including expected resolution timelines for the Contractor within 60 business days of receipt. Contractor will have 30 business days from the date of notice to correct errors or omissions and re-submit the report. Failure to submit the required report or correct errors or omissions may result in sanctions, per contract.

C. FORMAT:

Contractor shall submit the Provider Capacity Report to DMAP in the electronic format of Microsoft Excel. The field types and sizes are required and may be submitted in an alternate format if Contractor obtains prior approval from DMAP by contacting Contractor's Prepaid Health Plan Coordinator or designee.

REQUIRED DATA ELEMENTS

LINE	VARIABLE NAME	TYPE	SIZE	SPECIAL INSTRUCTIONS
1	CONTRACTOR NAME	A	50	The name of the Contractor that this Provider Capacity Report pertains to and is submitted by.
2	LAST NAME	A	50	Last name of the Provider. If the Provider has practices in multiple areas, complete a record line for each practice location.
3	FIRST NAME	A	25	First name of the Provider.
4	BUSINESS/PRACTICE ADDRESS	A/N	50	Address of the Provider's practice, including suite number. If the Provider does not have a practice address, list the business address. (i.e. lab/ diagnostic companies)
5	BUSINESS/PRACTICE CITY	A	20	City where the Provider's business is located.
6	BUSINESS/PRACTICE ZIP CODE	N	10	Formatted zip code - (9999) four digit code (i.e. 97214-1014)
7	BUSINESS COUNTY	A	15	The county in which the Provider's business is located.
8	PROVIDER TYPE	A	5	Table number 1 in subsection F of Exhibit E must be used.
9	SPECIALTY	A	15	Table number 2 in subsection F of Exhibit E must be used. If a specialty code does not apply, please use "not applicable".

10	PROVIDER'S DMAP NUMBER	A/N	6	DMAP assigned Provider number as supplied with Encounter Data. "999999" can be used if the Provider is not a PCP or the number is not known.
11	OTHER PROVIDER #	A/N	13	UPIN; The Provider's unique Provider identification number or (NPI). (Required only if 11, above, is "999999")
12	PRIMARY CARE PROVIDER (PCP) IDENTIFIER	A	1	Y = This Provider is a PCP. N = This Provider is not a PCP. DMAP
13	# MEMBERS ASSIGNED	N	4	Number of Contractor's DMAP Members currently assigned to this PCP or clinic.
14	# OF ADDITIONAL MEMBERS THAT CAN BE ASSIGNED TO PCP	N	5	Estimated number of additional members PCP will accept. If #12 = N, answer "0"
15	CREDENTIAL VERFICATION	N	8	Date Contractor verified or certified Provider's credentials (mm/dd/yy) as required in OAR 410-141-0120(1)(a).
16	SANCTION HISTORY	A/N	50	Brief description of any sanctions, fines or disciplinary actions that are currently active from the appropriate licensing board(s), DHS including DMAP, AMH, and SPD, DHS audit unit, Oregon Medicaid Fraud Unit, Oregon Secretary of State, Oregon Insurance Division, Oregon Department of Justice, U.S. Attorney or Department of Justice, CMS, or DHHS Office of Inspector General. If this is not applicable, answer "not applicable".
17	CONTRACT START DATE	A/N	25	mm/dd/yy Include a copy of new subcontracts since last report as required in Section 5, subsection Z (FCHP/ PCO), subsection S (DCO) or subsection R (CDO) and 42 CFR 438.230.
18	CONTRACT END DATE	A/N	25	mm/dd/yy. If contract is open-ended, answer 99/99/99 for end date.

D. CAPACITY BY SERVICE AREA

(1) Service Area as designated in Contract Section 3 Enrollment Limits – the individual Service Areas listed in the Contract.

(2) Total number of Primary Care Providers – the number of PCPs on panel for the designated service area.

(3) Total number of DMAP Members served – the unduplicated count of enrolled members receiving service in the preceding 12-month period. A service must qualify as an “Encounter” as defined in Exhibit D.

(1) DMAP Service Area as designated in Section 3 Enrollment Limits	(2) Total number of Primary Care Providers	(3) Total number DMAP Members served

Add lines as necessary for each Service Area.

E. PUBLICLY FUNDED PROGRAM INVOLVEMENT STATUS REPORT:

The following table details Contractor's involvement with publicly funded health care and service programs. Include those publicly funded health care and service programs with which Contractor has subcontracts.

Name of publicly funded program	Type of public program (i.e. county mental health dept.)	County in which program provides services	Description of the services provided in relation to Contractor's services	What has been the involvement of the public program in Contractor's operations (on the board, on Quality Assurance Committee, specify if subcontract, etc.)?

F. PROVIDER TYPE AND PROVIDER SPECIALTY CODE LISTING:

Two tables are found below: 1) the Provider/ Type code table and 2) Provider specialty code table. Use these codes to specify the required information on Contractor's Provider Capacity Report file as outlined in subsection (C), Required Data Elements, line number 9 of this Exhibit.

Provider Type Code	Provider Type	Provider Type Code	Provider Type
AA	Air Ambulance	NF	SNF/ICF
AC	Alcohol and Drug	NM	Midwives, direct entry
AD	Adult Day Health	NP	Nurse Practitioner
AF	Adult Foster Care	NT	Nutritionist under MCM
AM	Ambulance	OD	Optometrist
AS	Ambulatory Surgical	OP	Optician, dispensing
AT	Medical Air Transport	OT	Occupational Therapist
BC	Birthing Center	PB	Public Clinic
BP	Billing Provider	PH	Pharmacy
BR	Transportation Broker	PR	Pre-natal Clinic
CD	Contract Dentist	PS	Psychiatrist
CK	Medicheck Screening Center	PT	Physical Therapist
CR	Rural Health Clinic	PX	X-ray service
DC	Chiropractor	PY	Psychologist
DM	Dentist	RA	Personal Care RN
DO	Medical Doctor, Osteopath	RC	Residential Care Medical
DS	Podiatrist	RF	Residential Care
DT	Denturist	RH	Residential Care - HA
FC	Family Planning Clinic	RM	Residential Care - MR
FQ	FQHC	RN	Private Duty Nurse
HE	Hearing Aid Dealer	RT	Residential Treatment - Med
HF	Hemodialysis Facility	SC	Social Worker
HH	Home Health	SE	Secured Transportation
HI	HMO	SH	Audiologist/Speech Therapist
HK	Homecare	SL	Specialized Living Facility
HO	Hospital	SM	School Medical
HP	Hospice	SR	Satellite Apartment-Medical
IA	In Home Agency Provider	SS	Nursing Home Semi-Skilled
IH	Indian Health Clinic	TA	Taxi
IL	Independent Laboratory	TC	Targeted Case Management
KD	Kidney Dialysis	WC	Wheelchair
LF	Assisted Living Facility		
MC	MHO – AMH Provider		
MD	Physician		
MH	Mental Health		
MM	Miscellaneous Medical Svcs.		
MS	ICF/MR		
NA	Nurse Anesthetist		
ND	Naturopath		

PROVIDER SPECIALTY/SUB-SPECIALTY CODES

Use the codes on the following page to specify the required information on Contractor's Provider Capacity Report file as outlined in subsection (C), Required Data Elements, line number 10 of this Exhibit.

Specialty/ Sub-specialty	Code	Specialty/ Sub-specialty	Code
Allergy	AA	Neuropathology	NA
Abdominal Surgery	AB	Neoplastic Diseases	ND
Audiologist	AD	Neurology	NE
Adolescent	AE	Nephrology	NF
Allergy and Immunology	AL	Pharmacy Dispensing to Nursing Home	NH
Aviation Medicine	AM	Nuclear Medicine	NM
Anesthesiology	AN	Neonatal-Perinatal Medicine	NP
Bacteriology	BA	Nuclear Radiology	NR
Broncho-Esophagology	BE	Neurological Surgery	NS
Blood banking	BL	Nutrition	NT
Billing Service Nonpayable	BS	Ophthalmology	OA
Cardiology	CA	Obstetrics	OB
Clearinghouse Nonpayable	CB	Orthodontist	OD
Congregate Care	CC	Other Entity Nonpayable	OE
Cardiovascular Diseases	CD	Obstetrics & Gynecology	OG
Child Psychiatry	CH	Oral Surgery	OL
Child Neurology	CI	Occupational Medicine	OM
Federal Qualified Health Center	CL	Oncology	ON
Critical Care Medicine	CM	Oral Pathology	OP
Clinical Pathology	CP	Orthopedic Surgery	OR
Colon & Rectal Surgery	CR	Oral Surgeon	OS
Cardiovascular Surgery	CS	Otology, Laryngology, Rhino	OT
Dermatology	DE	Otology	OU
Diabetes	DI	Oxygen Supplies	OX
Misc Med Equip/ Supplies	DM	Pathology	PA
DME for Pharmacy	DN	Prosthodontics	PC
Osteopathic Physician	DO	Pediatrics	PD
Dermatopathology	DP	Periodontist	PE
Diagnostic Radiology	DR	Pediatric Allergy	PF
Endocrinology	ED	Pediatric Cardiology	PG
Emergency Medicine	EM	Public Health	PH
Endodontist	EN	Pediatric Endocrinology	PI
Forensic Pathology	FO	Pediatric Radiology	PJ
Family Practice	FP	Pediatric Surgery	PK
Gastroenterology	GD	Plastic Surgery	PL
Geriatrics	GE	Physical Medicine & Rehab	PM
General Dentist	GN	Psychiatry, Neurology	PN
General Practice	GP	Pediatric Hemotology-Onco	PO
Gynecology	GY	Pediatric Nephrology	PP
Hospital Administration	HA	Proctology	PR
Hospital Based Clinic (PCCM)	HC	Psychiatry	PS
Hearing Aids Dealer	HE	Pediodontist	PT
Hematology	HM	Pulmonary Diseases	PU
Head & Neck Surgery	HN	Preventive Medicine	PV
Hand Surgery	HS	Psychoanalysis	PW
House Calls, Inc Physician	HV	Psychosomatic Medicine	PX
Hypnosis	HY	Pharmacology	PY

Infectious Diseases	ID	Rheumatology	RE
Immunology	IG	Rhinology	RH
Internal Medicine	IM	Radioisotopic Pathology	RI
Intensive Outpatient Services	IO	Radiology	RR
Industrial Medicine	IP	Speech Therapist	ST
Kidney Dialysis Facility	KD	General Surgeon	SU
Laryngology	LA	Therapeutic Radiology	TR
Legal Medicine	LM	Thoracic Surgery	TS
Maxillofacial Surgery	MF	Traumatic Surgery	TU
Enteral/ Parenteral for HH, MM, PH, RN	MM	UOHSC Practitioners	UO
Medicheck Screen Clinic	MS	Urology	UR
Manipulative Therapy	MT	Opticians Contractor	VC
		Vascular Surgery	VS

Form E1 – Data Certification Form

This form shall be submitted by FAX to (503) 947-5221, following the electronic transmission of the Provider Capacity Report.

I, the undersigned, hereby attest that I have authority to certify the data and information and I, the undersigned, hereby certify based on best knowledge, information and belief that the data and information submitted to DMAP in the Provider Capacity Report is accurate, complete, and truthful.

____
Print Name/Title

____ ____________
Signature Date