

907 KAR 17:005 & E  
Managed Care Organization Requirements and Policies

Incorporated by Reference

The "MCO Reporting Requirements", July 2011 edition

The "MCO Program Integrity Requirements", July 2011 edition

The "Early and Periodic Screening, Diagnosis and Treatment Program Periodicity  
Schedule", July 2011 edition

The "Third Party Liability and Coordination of Benefits", July 2011 edition

The "Management Information Systems Requirements", July 2011 edition

Filed: October 28, 2011

## MCO REPORTING REQUIREMENTS

Report/Deliverable	Description	Frequency					Submit to
		Weekly	Monthly	Quarterly	Annual	Other	
<b>Financial</b>							
Annual Financial Statement	Relevant financial information in a structured format to include: Statement of Financial Position, Income Statement, Statement of Change in Equity, Cash Flow				X	120 days following each fiscal year	DOI
Annual Audited Financial Statement	Financial statements which have been prepared and certified by a Certified Public Accountant				X	Concurrent with filling with domiciliary insurance regulator	DOI/DMS
Quarterly Financial Reports	A report on trends in utilization for each category of eligibility, to include: inpatient hospital admissions and days per thousand Member months; outpatient hospital visits per thousand Member month; emergency room visits per thousand Member months; percent of emergency room visits resulting in admission; ambulatory surgery / procedures per thousand Member months; hospital readmissions within 30 days per thousand Member months; average visits per provider by major provider type; PRTF admits and days per thousand; mental hospital admits and days per thousand; prescriptions dispensed by major drug class per thousand Member months; pharmacy cost per Member per month. This report shall be display expenditures by category of service by both month of service and			X			DMS

**MCO REPORTING REQUIREMENTS**

	month of payment; this report should distinguish between the five major categories of eligibility (i.e. Families and Children, SSI Adults, SSI Children, Foster Care, and Dual Eligibles).								
<b>Executive</b>									
Executive Summary	Significant activities, problems or issues and program modifications					X		30 days after end of quarter	DMS
<b>Eligibility/Enrollment</b>									
Enrollment Changes During the Quarter	Summary of changes in the number of persons enrolled during the quarter					X		30 days after end of quarter	DMS
PCP Changes	Identify PCPs with voluntary enrollee changes and percent change in enrollees/PCP					X	X	30 days after end of quarter April 30 <sup>th</sup>	DMS
PCP Assignments by MCO	Number of PCP assignments by MCO					X		30 days after end of quarter	DMS

### MCO REPORTING REQUIREMENTS

PCP Changes by Enrollee	Number of enrollee PCP changes				X		30 days after end of quarter	DMS
PCPs Panel Changes	Electronic file of PCPs with panel changes greater than 50 (or 10%)				X		30 days after end of quarter	DMS
PCP Panel Change Narrative	Narrative of reasons for PCP panel changes by enrollee that exceed 50 (or 10%)				X		30 days after end of quarter	DMS
Member Services Report	Prior month's performance on call center abandonment rate, blockage rate and average speed of answer		X				By the 10 <sup>th</sup> of each month	DMS
<b>Access/Provider Network</b>								
Geo Access Report	Distribution and analysis of provider network and enrollees		X				By the 15 <sup>th</sup> of each month	DMS
Access Summary Report	Specific information on access problems identified and any corrective or remedial action taken or planned				X		30 days after end of quarter	DMS
Provider Participation Denials	Listing of providers requesting participation who were denied participation by MCO				X		30 days after end of quarter	DMS
Subcontractor Monitoring	Overview of monitoring of subcontracts/issues				X		30 days after end of quarter	DMS
<b>Quality Assurance and Improvement</b>								
QI Summary	Describe the quality assurance activities during the reporting period				X		30 days after end of quarter	DMS
QI Work Plan	Outline of scope of activities, goals, objectives and timeliness for QAPI program				X		30 days after end of quarter	DMS
QI Progress Report	Progress in baseline data, sampling methods used to validate data for QI plan/benchmarks and outcomes					X	July 31 <sup>st</sup>	DMS
Performance Improvement Projects (PIPs)	Progress and status of PIPs					X	July 31 <sup>st</sup>	DMS
Individuals with Special Health Care Needs and other Subpopulations	Issues regarding these special populations, including utilization				X		30 days after end of quarter	DMS

**MCO REPORTING REQUIREMENTS**

Committee Activity Report	Summary of activities of MCO committees			X	30 days after end of quarter	DMS
Satisfaction Survey (s)	Results of any satisfaction surveys during the reporting period			X	30 days after end of quarter	DMS
Practice Guidelines Report	Report on activities during the period in development and distribution of practice guidelines			X	30 days after end of quarter	DMS
EPSDT, Pregnant Women, and Maternal and Infant Death Activities	Summary of Activities/Changes/Trends, including outreach and education			X	30 days after end of quarter	DMS
Activity Overview	Summary of activities, changes, trends and summary of EPSDT approvals/denials			X	30 days after end of quarter	DMS
Credentialing & Recredentialing	Summary of credentialing and recredentialing activity during the reporting period			X	30 days after end of quarter	DMS
<b>Grievances &amp; Appeals</b>						
Grievance Activity	Member and provider grievances filed and resolved			X	30 days after end of quarter	DMS
Appeal Activity	Member and provider appeals filed and resolved			X	30 days after end of quarter	DMS
Appeals/Grievances Trends	Summary narrative of trends/problems areas and MCO efforts to address problem areas				30 days after end of quarter	DMS
<b>Fiscal</b>						
Quarterly Budget Issues	Narrative of budgetary issues, including changes in appropriations			X	30 days after end of quarter	DMS
Potential Fiscal Problems	Discussion of anticipated fiscal problems/issues			X	30 days after end of quarter	DMS
<b>Utilization</b>						
Enrollment Summary	Summary report of # of enrollees			X	30 days after end of quarter	DMS
Ambulatory Care by Age	Ambulatory utilization by age				April 30 <sup>th</sup>	DMS

## MCO REPORTING REQUIREMENTS

Emergency/Ambulatory Care Hospital Admissions	Number of emergency/ambulatory care visits resulting in hospital admission				X		April 30 <sup>th</sup>	DMS
Emergency Care by Diagnosis	Number of ER visits by ICD-9 code				X		April 30 <sup>th</sup>	DMS
Home Health Utilization	Quantity/Count of Home Health Services				X		April 30 <sup>th</sup>	DMS
Ambulatory Care by Provider Type and COA	Utilization data by provider type and category of aid				X		April 30 <sup>th</sup>	DMS
EPSDT Utilization (CMS-416)	Quantity/Count of EPSDT services				X		April 30 <sup>th</sup>	DMS
EPSDT Special Services	Special Services not mandated by Medicaid program but are mandated 42 CFR 1396			X		30 days after end of quarter		
<b>Pharmacy</b>								
Top 50 drugs	Report on top 50 drugs by utilization/cost				X		April 30 <sup>th</sup>	DMS
Top therapeutic classes	Report on top 50 drugs by therapeutic class – utilization/cost				X		April 30 <sup>th</sup>	DMS
Pharmacy Utilization	Utilization data Rx/Enrollee Cost/Enrollee Brand vs. Generic				X		April 30 <sup>th</sup>	DMS
Activity Report Utilization/Access to Care	Utilization Data and monitoring			X		30 days after end of quarter		DMS
Utilization Trends/Patterns	Narrative summary of trends/patterns identified			X		30 days after end of quarter		DMS
Denial Summary	Number of pharmacy denials			X		30 days after end of quarter		DMS
UM Calls				X		30 days after end of quarter		DMS
<b>Management Information Systems</b>								
Systems and Data Development	Report on status of systems and data development			X		30 days after end of quarter		DMS
Timeliness Claims/Encounters Processing	Status report on timeliness of encounter data reporting and claims processing and any actions taken to correct problems			X		30 days after end of quarter		DMS

## MCO REPORTING REQUIREMENTS

		Other Activities					
Organization Changes	Identify any organization changes during reporting period			X		30 days after end of quarter	DMS
Administration Changes	Identify any changes in administration			X		30 days after end of quarter	DMS
Innovations/Solutions	Provide information on additional or innovative program solutions during the reporting period			X		30 days after end of quarter	DMS
Operations	Provide any information relevant to the operations of the plan during the reporting period			X		30 days after end of quarter	DMS
Business Plan	Business plan that outlines proposed annual expenditures			X		30 days after end of quarter	DMS
Claims Report (DOI)	Claims report			X		180 days after end of quarter	DOI /DMS
COB Report			X			By the 15 <sup>th</sup> of every month	DMS
Medicare Cost Avoidance	Claims denied due to Medicare coverage		X			By the 15 <sup>th</sup> of every month	DMS
Cost Avoidance (non-Medicare)	Claims denied due to other insurance coverage		X			By the 15 <sup>th</sup> of every month	DMS
Potential Subrogation	Report of potential third party liability		X			By the 15 <sup>th</sup> of every month	DMS
Claims Processing			X			By the 15 <sup>th</sup> of every month	DMS
Prior Authorization	Approved and denied service activity		X			By the 15 <sup>th</sup> of every month	DMS
Paid Claims by Provider Type	Number of claims paid by provider type		X			By the 15 <sup>th</sup> of every month	DMS
Denials by Provider Type	Number of claims denied by provider type		X			By the 15 <sup>th</sup> of every month	DMS
Claims Suspended by Provider Type	Number of claims suspended by provider type		X			By the 15 <sup>th</sup> of every month	DMS

### MCO REPORTING REQUIREMENTS

Claims Inventory	Number of claims by provider type which exceed processing timelines standards		X		By the 15 <sup>th</sup> of every month	DMS
Encounter Data	Transactions/provider claims	X				DMS
Foster Care/Adoption Report	The number of service plan reviews conducted for members in foster care or receiving adoption assistance members, outcome decisions, such as referral to case management, and rationale for decisions.		X		By the 15 <sup>th</sup> of every month	DMS
Guardianship Report	The number of service plan reviews conducted for members in Guardianship status, outcome decisions, such as referral to case management, and rationale for decisions.		X		By the 15 <sup>th</sup> of every month	DMS
Provider Credentialing	Number of provider applications, processed, credentialled, enrolled and not enrolled		X		By the 15 <sup>th</sup> of every month	DMS
Provider Enrollments	Electronic provider enrollment file		X		By the 15 <sup>th</sup> of every month	DMS
Provider Terminations	Report on providers or subcontractors who have engaged in activities that resulted in suspension, termination or exclusion from MCO network		X		By the 15 <sup>th</sup> of every month	DMS
Provider Denials	Report on providers who have been denied participation in MCO network		X		By the 15 <sup>th</sup> of every month	DMS
Aged Accounts Receivables	Outstanding A/R 180 days or greater		X		By the 15 <sup>th</sup> of every month	DMS
Member Collections	Monies collected on members. Include number of mailings, responses and results.		X		By the 15 <sup>th</sup> of every month	DMS
Summary EOB Report	Total mailings, responses, actions and collections		X		By the 15 <sup>th</sup> of every month	DMS
Lock-in Report	Number of members locked into PCP, pharmacy and hospital. Paid claims data before and after lock-in			X	30 days after end of quarter	DMS

### MCO REPORTING REQUIREMENTS

Algorithm Report (Program Integrity)	Results of latest sampling	X		By the 15 <sup>th</sup> of every month	DMS
Provider Fraud Report	Open and closed cases of provider waste, fraud and abuse—include update on previous quarter	X		30 days after end of quarter	DMS
Member Fraud Report	Open and closed cases of member waste, fraud and abuse—include update on previous quarter	X		30 days after end of quarter	DMS
Quarterly Benefits Payment	Summary of monthly provider payments by category of service	X		30 days after end of quarter	DMS
Health Risk Assessments	Number of HRAs completed, not completed and refused	X		30 days after end of quarter	DMS
Provider Changes in Network	Network providers with open panels, closed panels and panel size	X		30 days after end of quarter	DMS
Out-of-network Utilization	Report on out-of-network within the MCO region and outside of MCO region	X		30 days after end of quarter	DMS
Subcontractor Status Report	Report on monitoring efforts of subcontractors/vendors	X		30 days after end of quarter	DMS
TPL Information Report	Report on other insurance of members	X		By the 15 <sup>th</sup> of every month	DMS
QAPI Program	Description of QAPI Program		X	July 31 <sup>st</sup>	DMS
QI Plan and Evaluation	Provide details of annual review and review of completed and continuing QI activities		X	July 31 <sup>st</sup>	DMS
Outreach Plan	EPSDT and non-EPSDT outreach activities, frequency, responsible staff, activities and evaluations		X	July 31 <sup>st</sup>	DMS
Member Services Report to Management	Copy DMS on member services report to management on changes in member services function to improve quality and delivery		X	July 31 <sup>st</sup>	DMS
Absent Parent Court Order Cancellation	Court order information from Division of Child Support Enforcement		X	July 31 <sup>st</sup>	DMS
Quality Access Advisory Committee	List of committee members		X	July 31 <sup>st</sup>	DMS
Performance Improvement Projects (PIPs) Proposal	Proposal for clinical and non-clinical focus areas		X	September 1 <sup>st</sup>	DMS
Abortion Report	Abortion procedures claims paid, include appropriate	X		30 days after	DMS

**MCO REPORTING REQUIREMENTS**

	number of children/youth who receive Impact Plus services under Impact Plus eligibility and the resulting services, by type and unit that were prior authorized				each month	
Utilization under 907 KAR 3:110	Monthly and year-to-date report of unduplicated number of children/youth who received substance abuse services	X			By the 15 <sup>th</sup> of each month	DBHDID
Pharmacy Utilization	Monthly and year-to-date report on pharmacy utilization for adults and children/youth with behavioral health diagnoses	X			By the 15 <sup>th</sup> of each month	DBHDID
Pharmacy Costs	Monthly and year-to-date report on pharmacy utilization and cost for children/youth who receive Impact Plus service	X			By the 15 <sup>th</sup> of each month	DBHDID
<b>Inpatient Psychiatric Hospitalization/Level I and II PRTEs-Admissions/Readmissions</b>						
Psychiatric Hospitalization Utilization	Monthly and year-to-date report of unduplicated number of adults and children/youth who received inpatient psychiatric hospitalization, PRTE and substance abuse services. Include length of stay and "discharged to" information. Include payor information.	X			By the 15 <sup>th</sup> of each month	DBHDID
Readmissions to psychiatric setting	Report quarterly and year-to-date the number and percentage of children/youth and adults readmitted within 30 days and 180 days to an inpatient hospital or PRTE	X				
<b>Behavioral Health Services Provided</b>						
Behavioral Health Services by Procedure Code	Monthly and year-to-date report of behavioral health utilization by procedure code. Number of unduplicated, units of service and paid amount of claim.	X			By the 15 <sup>th</sup> of each month	DBHDID
<b>Best Practices Outcomes</b>						
Number of Enrollees with SMI	Monthly and year-to-date unduplicated number and percentage of adults with SMI who live in independent/permanent housing	X			By the 15 <sup>th</sup> of each month	DBHDID
SED or Family Therapy Utilization	Monthly and year-to-date unduplicated number and percentage of children/youth with SED who received	X			By the 15 <sup>th</sup> of each month	DBHDID

## MCO REPORTING REQUIREMENTS

	Therapeutic foster care, multisystem therapy or family functional therapy								
Children with Trauma History	Monthly and year-to-date unduplicated number and percentage of children/youth with SED who were assessed for trauma history		X					By the 15 <sup>th</sup> of each month	DBHDID
Peer Support Services Utilization	Monthly and year-to-date unduplicated number of adults and children/youth or their caregivers who received a peer support service		X					By the 15 <sup>th</sup> of each month	DBHDID
Utilization for co-occurring mental health and SA disorders	Monthly and year-to-date of unduplicated number and percentage of adults with SMI and children/youth with SED who received assertive community treatment, supported employment, supportive housing, family psych education, integrated treatment for co-occurring mental health and substance abuse disorders, illness management/recovery or medication management		X					By the 15 <sup>th</sup> of each month	DBHDID
<b>Member Access</b>									
Treatment of Pregnant and Post-partum women with SA	Monthly and year-to-date number and percentage of pregnant and post-partum women with substance use disorders who received their first treatment within 48 hours of initial request for services		X					By the 15 <sup>th</sup> of each month	DBHDID
<b>Continuity of Care</b>									
Discharges from PRTF and Psychiatric facility	Quarterly and year-to-date on number and percentage of adults and children/youth discharged from an inpatient psych facility or PRTF who participate in an outpatient visit with 7 or 14 days of discharge		X					By the 15 <sup>th</sup> of each month	DBHDID
Discharges from Substance Abuse Program	Quarterly and year-to-date on number and percentage of adults and children/youth discharged from residential substance abuse treatment program who participate in an outpatient visit with 7 or 14 days of discharge		X					By the 15 <sup>th</sup> of each month	DBHDID

## MCO REPORTING REQUIREMENTS

Member Satisfaction						
Mental Health Statistics Improvement Project Survey	Annual report on the results of the administration of the Mental Health Statistics Improvement Project (MHSIP) adult survey. Results should be displayed as the number of individuals surveyed and the percentage reporting positively in the following seven areas: General satisfaction, Access, Quality/Appropriateness, Participation in Treatment Planning, Outcomes, Social Connectedness and Functioning			X	August 31st	DBHDID
Youth Services Satisfaction Survey	Annual report on the results of the administration of the Youth Services Satisfaction Caregiver (YSS-F) survey for children/youth. Results should be displayed as the number of individuals surveyed and the percentage rating positively in the following seven areas: General satisfaction, Access, Quality/Appropriateness, Participation in Treatment Planning, Outcomes, Social Connectedness and Functioning			X	August 31 <sup>st</sup>	DBHDID
Interface with Primary Care/Physical Health						
Adults and Children/Youth with Behavioral Health Diagnosis's with PCP	Quarterly and year-to-date reports of the number of children/youth and adults, with behavioral health diagnoses, who have a known Primary Care Provider (PCP)			X	30 days after end of quarter	DBHDID
Children/Youth with Behavioral Health Diagnoses Receiving Annual Wellness Check/Health Exam	Quarterly and year-to-date reports of the number of children/youth (up to age 21) and adults (18 +) with behavioral health diagnoses who receive annual wellness check/annual physical health exams.			X	30 days after end of quarter	DBHDID
Adults and Children/Youth General Behavioral Health Diagnosis and Chronic Physical Health Diagnosis	Quarterly and year-to-date reports of the number of children/youth (up to age 21) and adults (general behavioral health and with SMI designation) with both an Axis I behavioral health diagnosis and a chronic (physical) health diagnosis.			X	30 days after end of quarter	DBHDID

## MCO REPORTING REQUIREMENTS

Unduplicated Number of Adults and Children/Youth with Regular use of Tobacco Products	Annual report of the number of children/youth (up to age 18) and adults (18+) who report regular use (once a week or greater) of tobacco products (all types).			X		April 30 <sup>th</sup>	DBHDID
Number of Adults and Children/Youth Screened for Substance Use Disorder in Physical Care Setting	Quarterly and year-to-date report on the unduplicated number of children/youth (up to age 18) and adults (18+) who are screened for a substance use disorder in a physical care setting (including ER, primary care, specialized care, other)		X		30 days after end of quarter		DBHDID

## **MCO Reporting Requirements**

*(Appendix K)*

These report formats and accompanying report templates are used by the Kentucky Department for Medicaid Services (DMS) to monitor and evaluate the Contractor's performance and to inform CMS and other interested parties of activities and progress on a quarterly basis. The reports should be a detailed rather than a general treatment of issues and events of the reporting period. All information in these reports should be for the most recent three-month period unless otherwise noted and submitted within ten (10) days of the end of each reporting period.

The Contractor shall review all reports for accuracy and completeness prior to submitting to the Department. Any noticeable variances identified in report comparisons shall include a detailed explanation which explains the reason for the discrepancy and the actions taken to resolve the problem, if applicable.

Utilization data for reports in Appendices K and L should be reported annually for the twelve (12) month period beginning with January 1 through December 31 and should allow a 90-day run out period past the end of the twelve-month period.

## I. EXECUTIVE SUMMARY

Provide an overview of the content of the report summarizing each topic. The Contractor should include summarize significant activities during the reporting period, problems or issues during the reporting period, and any program modifications that occurred during the reporting period. The overview should also contain success stories or positive results that were achieved during the reporting period, any specific problem area that the Contractor plans to address in the future, and a summary of all press releases and issues covered by the press.

## II. ELIGIBILITY/ENROLLMENT

### A. Enrollment Changes During the Quarter

Summarize all changes in the number of persons enrolled during the report period. Include a summary discussion of enrollees by aid category and by age according to Utilization Report #1, Enrollment Summary (see example table below). Discuss the trends in enrollment and any issues or concerns related to enrollment. Discuss any plans or outreach efforts to expand enrollment to qualified potential members.

### B. PCP Changes During the Report Period

(These reports are required on a quarterly basis, and once annually. The Annual Report is produced by analyzing the top 10% providers for each quarter, combining them into one report. Any physician/group can be listed up to four times in the table for the annual report.)

Identify PCPs with voluntary member enrollment change activity and the percent change in members per PCP. A member enrollment change is defined as any change in a members PCP assignment for reasons other than member disenrollment. This report should be based on the PCP's total panel size, not his/her office location panel size. The following tables provide example layouts:

**PCP Changes During the Report Period**

Physician/ Group ID	Physicia n/Group Name	Beginning Panel Enrollment Size	Number of Members that requested voluntary change	Overall Net Change (+/-) in Panel Enrollment Size	Ending Panel Enrollment Size	Percent Change	PCP Assignment initiated by who: Member, Provider or Contractor
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- C. **PCP's with Panel Changes Greater than 50 or 10%**  
 Briefly narrate reasons for those voluntary member transfers that exceed the lessor of 50 or 10% of total panel. The purpose for the change is to place emphasis on looking at reasons for voluntary changes and less on routine member transfers due to new enrollment activity. (See note under B. above for annual report)

**PCP's with Panel Changes Greater than 50 or 10%**

Provide an electronic copy of PCPs w/n panel changes greater than 50% or 10% format below	Physician/Group ID	Physician /Group Name	Begin ning Panel Enrollment Size	Number of Members that requested voluntary change	Percent Change	Ending Panel Enrollment Size
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**III. ACCESS/DELIVERY NETWORK**

- A. **GeoNetworks Reports and Maps**  
**Distribution and Analysis of Current Provider Network and Beneficiaries**  
 Annually, due on July 31 of each year include the following GeoNetworks reports: Title page, table of contents, accessibility standard comparison, accessibility standard detail, accessibility detail, accessibility summary, member map, provider listing, provider map, service area detail. Discuss monitoring and analysis of the GeoNetwork reports and maps to determine utilization patterns especially those of Members with special healthcare needs. Do not include member listing. Include a 3 computer diskette containing the GeoNetworks .dbf files used for the members and providers as well as the GeoNetworks .rpt file(s).
- B. **Access Issues/Problems Identified During the Report Period and/or Remedial Action Taken**  
 Provide specific information on the nature of any access problems identified and any plans or remedial action taken. Include a summary of all provider and member complaints about access issues, responses to member and provider survey questions dealing with access, analysis of GeoAccess reports, and notification of the Contractor by DMS of network access problems.
- C. **Listing of Providers Denied Participation**  
 Provide a listing of providers that requested participation in the MCO network during the report period but were denied. Include reasons for denials.
- Provide a summary (count) of providers that terminated their contract(s) with the Contractor during the report period and the reasons for the terminations. (Sample listing of termination reasons below. Add other

reasons as needed.)

<b>Reason for Provider Termination</b>	<b>Number</b>
Retired	
Deceased	
Moving Out of Service Area	
Cap/Fees Too Low	
No Longer Accepting Medicaid	
Does Not Meet Credentialing Criteria	
Terminated Due to Quality Assurance	
Administrative	
Site Closed - Bankrupt	
Group Practice Dissolved Doctors Billing	
Moved New Location Unknown	
Rates Too Low	
Request By Provider	
Closed Office	
Precluded From Medicaid	
Due to IPA Contracting	
Refused MAID Application	
No Medicaid ID#	
<b>Total Terminated Providers</b>	

- D. **Subcontracting Issues/Monitoring Efforts**  
 Provide an overview of all monitoring efforts of all subcontractors and vendors, including those responsible for the delivery of ancillary services, i.e., pharmacy, dental, vision, and transportation (if applicable), as well as information systems, utilization review, and credentialing vendors. Provide brief summaries of all delegation oversight committee reports/minutes for the report period and attach quarterly reports.

#### **IV. QUALITY ASSURANCE AND IMPROVEMENT**

- A. **Internal Quality Assurance Activities During the Report Period**
1. **Summary of QI Activities**  
 Describe the quality assurance activities during the report period directed at improving the availability, continuity, and quality of services. Examples include problems identified from utilization review to be investigated, medical management committee recommendations based on findings, special research into suspected problems and research into practice guidelines or disease management.
  2. **Monitoring of Indicators, Benchmarks and Outcomes**  
 Include a narrative on the Contractor's progress in developing or obtaining baseline data and the required health outcomes, including proposed sampling methods and methods to validate data, to be used as a progress comparison for the Contractor's quality improvement plan. The report should include how the baseline

data for comparison will be obtained or developed and what indicators of quality will be used to determine if the desired outcomes are achieved.

3. Performance Improvement Projects  
Report on the progress and status of performance improvement projects.
  4. Utilization of Sub-Populations and Individuals with Special Healthcare Needs  
Discuss any issues that arose during the report period that related to persons associated with sub-populations and individuals with special healthcare needs. Examples of sub-populations and individuals with special health care needs include members with chronic and disabling conditions, minorities, children enrolled with the Commission for Children with Special Health Care Needs, persons receiving SSI, persons with mental illness, the disabled, homeless, and any groups identified by the Contractor for targeted study. Discuss progress in the development of new or ongoing outreach and education to these special populations.
  5. Satisfaction Survey(s)  
Describe results of any satisfaction survey that was conducted by the Contractor during the report period, if applicable. *(Note: surveys are conducted each year, so this section will be completed during one quarter for the providers and one for the members.)*
  6. Evidence-based guidelines for practitioners  
Report on assessment activities during the report period resulting in development and distribution of practice guidelines for providers. Provide an analysis of the effectiveness in improving patterns of care.
- B. Activities Related to EPSDT, Pregnant Women, Maternal and Infant Health
1. Overview of Activities  
Provide a summary of the activities of these programs, and trends noted in prenatal visit appropriateness, birth outcomes including death, and program interventions, during the last reporting period. If any of the programs have changed during the reporting period, please describe the change in the programs.
  2. EPSDT Screening Rates  
Describe activities of the EPSDT staff, including outreach, education, and case management. Provide data on levels of compliance during the report period (including screening rates) with EPSDT regulations.

The CMS-416 report is an additional report required annually. The Department specifications for the CMS 416 (EPSDT) shall be in compliance with the CMS-416: Annual EPSDT Participation Report

and shall be based on Federal Fiscal Year (FFY).

- C. **Credentialing and Re-credentialing Activities During the Report Period**  
Summarize the Contractor's credentialing and re-credentialing activities.
- D. **Fraud, Waste and Abuse Activities During the Report Period**  
Discuss Contractor efforts to monitor Fraud, Waste and Abuse.

## **V. GRIEVANCES/APPEALS**

- A. **Grievance Activities During the Report Period**  
Summarize the grievances received by the Contractor during the reporting period. Provide the number, type and resolution of grievances during the report period. (Note: these logs are the "number, type and resolution." Also under the BBA – complaint and grievances are the same.)
- B. **Appeal Activities during the Report Period**  
Summarize the appeals received by the Contractor during the reporting period. Provide the number, type and resolution of appeals during the report period.
- C. **Trends or Problem Areas**  
Discuss any trends or problem areas identified in the appeals and grievances, and the Contractor's efforts to address any trends.

## **VI. BUDGET NEUTRALITY/FISCAL ISSUES**

- A. **Budgetary Issues for the Report Period**  
Provide a narrative of budgetary issues including changes in appropriations, adjustments in the upper payment limits, etc.
- B. **Potential/Anticipated Fiscal Problems**  
Provide a narrative of anticipated fiscal problems or issues at the Contractor level. Include such topics as payment of claims, financial solvency, etc.

## **VII. UTILIZATION**

- A. **Utilization Summary Data Reports**
  - 1. Enrollment Summary Report
  - 2. Ambulatory Care by Age Breakdown
  - 3. Emergency Care and Ambulatory Surgery Resulting in Hospital Admission
  - 4. Emergency Care by ICD-9 Diagnosis (Emergency Care by ICD-10 Diagnosis upon implementation)
  - 5. Home Health
  - 6. Ambulatory Care by Provider Category and Category of Aid
  - 7. Pharmacy Report
    - a) Top 50 Drugs – Cost, Number of Prescriptions
    - b) Top Therapeutic Classes based on top 50 Drugs – Cost and Number of Prescriptions

c) Pharmacy Utilization Statistics

B. Templates for Utilization Reports

The Department for Medicaid Services and the Contractor will review the utilization reporting formats regarding any necessary updates to the formatting of the reports. This review will be completed for the purposes of ensuring accuracy of the reports and meaningful information sharing.

<b>UTILIZATION REPORT 1 - ENROLLMENT SUMMARY</b>							
<b>Region XX</b>							
<b>Reporting Period Covers: __/__/__ - __/__/__</b>							
<b>First Month of The Report Period</b>							
<b>Unduplicated Number of Members During the Month By Age And Category of Medicaid Eligibility</b>							
<b>AGE</b>	<b>AFDC</b>	<b>SOBRA</b>	<b>FOSTER</b>	<b>KCHIP</b>	<b>SSI W/ MEDICARE</b>	<b>SSI WO/ MEDICARE</b>	<b>TOTAL</b>
< 1							
1 < 2							
2 < 3							
3 < 6							
6 < 10							
1 - 9							
10 - 19							
20 - 44							
45 - 64							
65 - 74							
75 - 84							
85+							
Total							
<b>Second Month of The Report Period</b>							
<b>Unduplicated Number of Members During the Month By Age And Category of Medicaid Eligibility</b>							
<b>AGE</b>	<b>AFDC</b>	<b>SOBRA</b>	<b>FOSTER</b>	<b>KCHIP</b>	<b>SSI W/ MEDICARE</b>	<b>SSI WO/ MEDICARE</b>	<b>TOTAL</b>
< 1							
1 < 2							
2 < 3							
3 < 6							
6 < 10							
1 - 9							
10 - 19							
20 - 44							
45 - 64							
65 - 74							
75 - 84							
85+							

Total							
<b>Third Month of the Report Period</b>							
<b>Unduplicated Number of Members During the Month By Age And Category of Medicaid Eligibility</b>							
AGE	AFDC	SOBRA	FOSTER	KCHIP	SSI W/ MEDICARE	SSI WO/ MEDICARE	TOTAL
< 1							
1 < 2							
2 < 3							
3 < 6							
6 < 10							
1 - 9							
10 - 19							
20 - 44							
45 -64							
65 - 74							
75 - 84							
85+							
Total							
<b>Total Member Months During the Report Period By Age And Category of Medicaid Eligibility (Note: Sum the months above for each cell)</b>							
AGE	AFDC	SOBRA	FOSTER	KCHIP	SSI W/ MEDICARE	SSI WO/ MEDICARE	TOTAL
< 1							
1 < 2							
2 < 3							
3 < 6							
6 < 10							
1 - 9							
10 - 19							
20 - 44							
45 -64							
65 - 74							
75 - 84							
85+							
Total							
Version: DMS Approved 06/2011							
Notes: All reports are based on date of service							
Unduplicated members include all members eligible at any time during the month regardless of date.							
Retroactive eligibility <b>shall</b> be included in the "total" table. Footnote accordingly.							
For report periods greater than 3 months, simply include a table for each month.							

**Utilization Report 2**

Region XX

Reporting Period Covers:   /  /  

Ambulatory Care by Age Breakdown

Age	Outpatient Visits (Excludes MH/CD)		All Emergency Room Visits (Include outpatient ER and ER resulting in inpatient admissions)		Ambulatory Surgery / Procedures		Observation Room Stays Resulting in Discharge	
	Visits	Visits / 1,000 Member Months	Visits	Visits / 1,000 Member Months	Procedures	Procedures / 1,000 Member Months	Stays	Stays / 1,000 Member Months
<1								
1-9								
10-19								
20-44								
45-64								
65-74								
75-84								
85+								
Total								

Version: DMS Approved 06/2011

Notes: All reports are based on date of service

ER Utilization shall be according to HEDIS specifications to include HCFA-1500 Claims with Place of Service code 23.

**UTILIZATION REPORT 3**

Region XX

Reporting Period Covers: 11 - 11

**Emergency Care and Ambulatory Surgery Resulting in Hospital Admission**

Age	Emergency Room Visits Resulting in Inpatient Admission Same Day		Ambulatory Surgery / Procedures* Resulting in Inpatient Admission within 30 days	
	Visits	Visits / 1,000 Member Months	Procedures	Procedures / 1,000 Member Months
<1				
1-9				
10-19				
20-44				
45-64				
65-74				
75-84				
85+				
Total				

Version: DMS Approved 06/2011

\* Use the Medicare base rate file for ambulatory surgery procedures



**UTILIZATION REPORT 5**

Region XX

Reporting Period Covers:   /  /   -   /  /  

**Home Health Utilization**

Age	Unduplicated Patients Served	Visits for Infusion Therapy	Visits for Oxygen and/or Respiratory Therapy	Visits for Physical Therapy	Visits for Occupational Therapy	Visits for Speech Therapy	Other Visits	Total Visits	Total Visits / 1,000 Member Months
<1									
1-9									
10-19									
20-44									
45-64									
65-74									
75-84									
85+									
Total									

Use revenue codes and HCPC codes appropriate for RN, LPN, RT, OT, PT, ST, CNA, Oxygen and Respiratory Therapy, Infusion Therapy.

Do not include DME in this report.

Version: DMS Approved 06/2011

Note: All reports based on date of service.

Utilization 6  
Region XX

Reporting Period Covers:   /  /   -   /  /  

**Ambulatory Care by Provider Type and Category of Aid**

Category	Visits w/ Participating Providers	Visits w/ Non- participating Providers	Total Visits	Visits / 1,000 Member Months
<b>1. Primary Care Providers</b>				
AFDC				
SOBRA				
Foster Care				
KCHIP				
SSI w/o Medicare				
SSI w/ Medicare				
<b>2. FQHC &amp; RHC</b>				
AFDC				
SOBRA				
Foster Care				
KCHIP				
SSI w/o Medicare				
SSI w/ Medicare				
<b>3. Eye Care Providers</b>				
AFDC				
SOBRA				
Foster Care				
KCHIP				
SSI w/o Medicare				
SSI w/ Medicare				
<b>4. Dentists</b>				
AFDC				
SOBRA				
Foster Care				
KCHIP				
SSI w/o Medicare				
SSI w/ Medicare				
<b>5. Physician Specialists</b>				
AFDC				

SOBRA				
Foster Care				
KCHIP				
SSI w/o Medicare				
SSI w/ Medicare				
6. Home Health				
AEDC				
SOBRA				
Foster Care				
KCHIP				
SSI w/o Medicare				
SSI w/ Medicare				
Version: DMS Approved 06/2011				
Notes: All reports are by date of service.				

**UTILIZATION REPORT 7A - Top 50 Drugs**

**Region XX**

**Reporting Period Covers:   /  /   -   /  /**

	<b>Drug</b>	<b>Cost</b>	<b>Number of RX per Quarter</b>
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32			
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50			

**UTILIZATION REPORT 7B - Top Therapeutic Classes (Based on Top 50 Drugs)**

**Region XX**

**Reporting Period Covers: \_\_/\_\_/\_\_ - \_\_/\_\_/\_\_**

<b>Top Therapeutic Class</b>	<b>Cost</b>	<b>Total Number of RX</b>		
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
(Add more rows as needed per the top 50 drugs.)				

## UTILIZATION REPORT 7C - Pharmacy Utilization by Month

Region XX

Reporting Period Covers: \_\_\_ - \_\_\_

Month	# Members utilizing RX benefit	Total RX per month	Cost PMPM (All drug Costs)	
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
Yearly Total:				

### Total RX Utilization Brand Vs. Generic

Month	Generic Rx Total	Percent of Total	Brand Rx Total	Percent of Total
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
Yearly Total:				

- C. **Monitoring Activities Related to Utilization and Access to Care**  
Discuss the Contractor's use of encounter data and utilization reports to monitor utilization of services and access to care.
- D. **Utilization Trends/Patterns Identified During the Report Period**  
Analyze and discuss trends in utilization and any unusual patterns about which the Contractor will take subsequent action. Also, discuss areas where over- or under-utilization has been influenced appropriately, i.e., pharmacy and ER utilization management.
- E. **Summary of Denials Rendered during the Report Period**  
Analyze and discuss any unusual patterns in the denials rendered during the reporting period.

### **VIII. Quarterly Benefit Payment Report**

The Quarterly Benefit Payments Report summarizes Medicaid payments by category of service for each month during the reporting quarter. In addition, KCHIP, reinsurance and pharmacy rebate totals are included to calculate a grand total for the program. KCHIP monthly totals are derived from the Quarterly Benefit Payments – KCHIP Members Only Report. Reports shall:

- Include column headings on each page;
- Be submitted in Excel format;
- Be completed for each MCO region, in addition to a summary of all MCO regions; and

**CONTRACTOR  
REGION X  
DEPARTMENT FOR MEDICAID SERVICES  
QUARTERLY BENEFIT PAYMENTS  
STATE FISCAL YEAR XXXX**

COS #	Category of Service	October-	November-	December-	Quarterly Total
-------	---------------------	----------	-----------	-----------	-----------------

**Medicaid Mandatory Services**

02	Inpatient Hospital				
12	Outpatient Hospital				
32	EPSDT Related				
34	Clinical Social Worker				
37	Physical Therapist Crossover				
38	Occupational Therapist				
39	Psychologist Crossover				
40	DME				
41	Primary Care				
43	Rural Health Clinic				
44	Nurse Midwife				
5	Family Planning				
6	Home Health				
47	Independent Laboratory				
48	EPSDT Preventive				
62	Emergency Transportation				
63	Non-Emergency Transportation				
67	Vision				
72	Dental				
74	Physician				
75	Certified Nurse Practitioner				
81	Hearing				
90	Comprehensive Outpatient Rehab Facility (CORF)				
92	Psychiatric Distinct Part Unit				
93	Rehab Distinct Part Unit				
94	Physician Assistant				
	<b>Subtotal</b>	\$	\$	\$	\$

**Medicaid Optional Services**

03	Mental Hospital				
04	Renal Dialysis Clinic				
3	Psychiatric Residential Treatment Facility (PRTF)				

3	Ambulatory Surgery				
6	Impact Plus				
17	Specialized Children's Services Clinic				
20	Targeted Case Management – Adults				
21	Targeted Case Management – Children				
24	Commission for Children with Special Health Care Needs				
29	Preventive Health				
35	Chiropractor				
36	Other Lab & X-Ray				
42	Community Mental Health Center (CMHC)				
54	Nurse Anesthetist				
55	Hospice – Non Institutional				
64	Pharmacy				
88	Podiatry				
99	Unknown Type				
	<b>Subtotal</b>	\$	\$	\$	\$

	<b>KCHIP</b>	\$	\$	\$	\$
--	--------------	----	----	----	----

	<b>TOTAL</b>	\$	\$	\$	\$
--	--------------	----	----	----	----

	<b>Reinsurance</b>	\$	\$	\$	\$
--	--------------------	----	----	----	----

	<b>Pharmacy Rebates</b>	\$	\$	\$	\$
--	-------------------------	----	----	----	----

	<b>GRAND TOTAL</b>	\$	\$	\$	\$
--	--------------------	----	----	----	----

**CONTRACTOR  
REGION X  
DEPARTMENT FOR MEDICAID SERVICES  
QUARTERLY BENEFIT PAYMENTS – KCHIP MEMBERS ONLY  
STATE FISCAL YEAR XXXX**

COS #	Category of Service	October-	November-	December-	Quarterly Total
-------	---------------------	----------	-----------	-----------	-----------------

**Medicaid Mandatory Services**

02	Inpatient Hospital				
12	Outpatient Hospital				
32	EPSDT Related				
34	Clinical Social Worker				
37	Physical Therapist Crossover				
38	Occupational Therapist				
39	Psychologist Crossover				
40	DME				
41	Primary Care				
43	Rural Health Clinic				
44	Nurse Midwife				
45	Family Planning				
46	Home Health				
47	Independent Laboratory				
48	EPSDT Preventive				
62	Emergency Transportation				
63	Non-Emergency Transportation				
67	Vision				
72	Dental				
74	Physician				
75	Certified Nurse Practitioner				
81	Hearing				
90	Comprehensive Outpatient Rehab Facility (CORF)				
92	Psychiatric Distinct Part Unit				
93	Rehab Distinct Part Unit				
94	Physician Assistant				
	<b>Subtotal</b>	\$	\$	\$	\$

**Medicaid Optional Services**

03	Mental Hospital				
04	Renal Dialysis Clinic				
05	Psychiatric Residential Treatment Facility (PRTF)				

	Ambulatory Surgery				
16	Impact Plus				
17	Specialized Children's Services Clinic				
20	Targeted Case Management – Adults				
21	Targeted Case Management – Children				
24	Commission for Children with Special Health Care Needs				
29	Preventive Health				
35	Chiropractor				
36	Other Lab & X-Ray				
42	Community Mental Health Center (CMHC)				
54	Nurse Anesthetist				
55	Hospice – Non Institutional				
64	Pharmacy				
88	Podiatry				
99	Unknown Type				
	<b>Subtotal</b>	\$	\$	\$	\$
	<b>TOTAL</b>	\$	\$	\$	\$
	<b>Reinsurance</b>	\$	\$	\$	\$
	<b>Pharmacy Rebates</b>	\$	\$	\$	\$
	<b>GRAND TOTAL</b>	\$	\$	\$	\$

### IX. Abortion Procedure Report

An Abortion Procedure Report shall be submitted each quarter to the Department. The report shall list all claims paid with an abortions procedure code and be submitted with supporting documentation (i.e. doctor's notes, etc.) that justify the service was performed in accordance with federal and state laws and judicial opinions. Currently, abortion claims can only be paid by Medicaid for three reasons (rape, incest and when the mother's life is at risk). The Abortion Procedure Report shall contain the following fields:

- MCO Region
- Member ID
- Member DOB
- Provider ID
- Claim ICN

- FDOS (First Date of Service)
- LDOS (Last Date of Service)
- Paid Amount

## **X. Systems**

### **A. Systems and Data Development Issues**

Discuss the status of systems and data development and issues. Include information on plan modification and expected outcomes.

### **B. Claims Processing Timeliness/Encounter Data Reporting**

Provide a discussion of the status on the timeliness of encounter data reporting and the processing of claims, including steps taken by the Contractor to correct problems.

## **XI. OTHER CONTRACTOR ACTIVITIES**

### **A. Organization Changes**

Identify organizational changes relating to the Contractor.

### **B. Administrative Changes**

Identify administrative changes relating to the Contractor.

### **C. Innovations Solutions**

Provide information on additional or innovative program solutions implemented by the Contractor as referenced in the RFP.

MCO shall recommend innovative programs to assist in controlling pharmacy and other medical costs through such mechanisms

### **D. Other**

Provide any information relevant to the operation of the Contractor not otherwise covered herein.

## **XII. Behavioral Health, Developmental and Intellectual Disabilities (BHDID)**

### **A. BHDID General Reporting Requirements**

BHDID reports shall be provided with display of the following fields and should have detailed report definitions. Report should include "totals" and be delineated by the following:

1. Age (0 - <18, 18 - <21 receiving service under child benefit), 18 and above for those receiving services under adult benefit
2. Gender
3. Diagnostic category or diagnoses
4. SMI
5. SED
6. County
7. Zip Code
8. Provider

### **B. BHDID Additional Reporting Requirements**

#### **1. Network Capacity**

MCO will provide quarterly reports on staffing within the behavioral health network to include:

##### **a) FTEs per 1000 Chronic Cases**

- Psychiatrists FTE/1000
- Ph.D. psychologists/1000
- other PhDs/1000
- MA Psychologists/1000
- Total licensed (for independent practice) therapists FTE/1000 (by discipline LMFT, LPCC, LCSW, etc.)
- Total master's level therapists under supervision FTE/1000 (by discipline)
- MSWs/1000
- BAs/1000
- Targeted case managers /1000
- Other support staff / 1000
- Peer support specialists / 1000

##### **b) Utilization by Chronic Cases**

- Number of crisis calls/1000
- Number of counseling sessions/1000

##### **c) Number of days wait for initial appointment**

- Total
- Emergency
- Urgent
- Routine

##### **d) Utilization by Medicaid Enrollees**

- Number of crisis calls/1000

- Number of counseling sessions/1000
  - Number of days wait for initial appointment (Should include: Total; Emergency; Urgent; and Routine)
  - Number of Minutes to Reach a Clinician by Telephone in an Emergency
  - Number of Days to Reach a Clinician by Telephone (non-emergency)
  - Prevention Visits per 1000 Medicaid Enrollees
- e) Outcomes for Chronic Cases (SMI,SED)
- Number of psychiatric hospitalizations/1000
  - Percent hospitalized
  - Pharmaceutical expenditures/1000
  - Number ER visits/1000
  - Percent adhering to recommended course of mental health treatment
  - Percent of clients satisfied with access and quality of mental health services
  - Percent maintaining employment or staying in school while in mental health treatment
  - Percent with permanent housing after mental health treatment
  - Percent arrested or incarcerated after mental health treatment
  - Health status
- f) Outcomes for Medicaid Enrollees
- Number of psychiatric hospitalizations/1000
  - Percent hospitalized for psychiatric problems
  - Pharmaceutical expenditures/1000
  - Number ER visits/1000
  - Percent adhering to recommended course of behavioral health treatment
  - Percent of clients satisfied with access and quality of behavioral health services
  - Percent maintaining employment or staying in school while in mental health treatment
  - Percent with permanent housing after mental health treatment
  - Percent arrested or incarcerated after mental health treatment
  - Health status

2. Financial / Payment
  - a) MCO shall be required to make payments to providers upon receipt of filed claims (not to exceed thirty days or with respective penalty after sixty days, ninety days, etc.)
  - b) MCO shall report monthly on per member, per month expenses for behavioral health services for children / youth and for adults
  - c) MCO shall report monthly on per member, per month expenses for behavioral health services for adults with SMI and children/youth with SED

**XIII. Other Quarterly Report**

**Personal Information Form Template**

	<b>Total # of New Member Packets Mailed by Month</b>	<b>Total # of PIFs Received by Month</b>
October	0	0
November	0	0
December	0	0
<b>Total for Quarter</b>	<b>0</b>	<b>0</b>

  

**New Member Enrollment Report: Phone Call Results by Date Span  
00/00/00 to 00/00/00**

<b>Call Result</b>	<b>1st Attempt: Call Results</b>	<b>2nd Attempt: Call Results</b>	<b>Grand Total: Call Results</b>
No Answer	0	0	0
Phone number incorrect	0	0	0
Left message	0	0	0

Phone number not listed	0	0	0
Member disenrolled from Contractor	0	0	0
Not convenient time	0	0	0
Member not home	0	0	0
Did Not Want Assistance	0	0	0
Phone Busy	0	0	0
Assisted Member to Fill Out PIF	0	0	0
Doesn't speak English	0	0	0
Filled Out PIF and Mailed	0	0	0
<b>Total # of call results:</b>	<b>0</b>	<b>0</b>	<b>0</b>

**Health/Disease Management and Case Management follow-up Report:  
00/00/00 to 00/00/00**

<b>Call Result</b>	<b>Total Number:</b>
Filled Out PIF and Mailed	0
Completed Call	0
Member no longer at this phone number	0
No Phone Number Listed	0
Phone number incorrect	0
Assisted Member to Fill Out PIF	0
Left Message	0
Member not home	0
No Answer	0
<b>Total # of call results</b>	<b>0</b>

<b>Provider Termination Report</b> <b>Monthly Report - Month/Year</b> <b>Ran as of Date - MM/DD/YY</b>											
NPI	Last	First	Title	Group	Add 1	Add 2	City	St	Zip	County	Reason

<b>Provider Denial Report</b> <b>Monthly Report - Month/Year</b> <b>Ran as of Date - MM/DD/YY</b>											
NPI	Last	First	Title	Group	Add 1	Add 2	City	St	Zip	County	Reason

**Outstanding Accounts Receivable Report**  
**Monthly Report - Month/Year**  
**Ran as of Date - MM/DD/YY**

<u>Provider FEIN/SSN</u>	<u>Medicaid ID</u>	<u>Provider NPI</u>	<u>Provider Name</u>	<u>Date of AR Setup</u>	<u>Age of AR</u>	<u>Reason for Setup</u>	<u>Original Amount of AR</u>	<u>Balance of AR</u>	<u>TPL Indicator</u>

<b>Provider Case Report</b> <b>Quarterly Report - Quarter/Year</b> <b>Ran as of Date - MM/DD/YY</b>							
<b>Case Number</b>	<b>Investigator</b>	<b>Subject Type</b>	<b>Date Opened</b>	<b>Date Closed</b>	<b>Original Report Summary</b>	<b>Findings</b>	<b>Potential Recovery</b>


**Member Case Report**  
**Quarterly Report - Quarter/Year**  
**Ran as of Date - MM/DD/YY**

<b>Case Number</b>	<b>Investigator</b>	<b>Subject Type</b>	<b>Date Opened</b>	<b>Date Closed</b>	<b>Original Report Summary</b>	<b>Findings</b>	<b>Potential Recovery</b>

**Monthly Provider Enrollment Report**

<b>NPI</b>	<b>Provider Name</b>	<b>Tax ID</b>	<b>Owner</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>	<b>County</b>

**Expenditures Related to Contractor's Operations**

Category	Positions	Salary	Bonus	Other			Other Expenses	Reporting Period	
				Compensation	Travel	Expenses		Begin Date	End Date
Board	Board Member								
Board	Supporting Staff								
Board	Sub-Total								
Executive Management	Executive Officer/CEO								
Executive Management	Medical Director								
Executive Management	Pharmacy Director								
Executive Management	Dental Director								
Executive Management	CFO								
Executive Management	Compliance Director								
Executive Management	Quality Improvement Director								
	Sub-Total								
Executive Management	All other Executive Management Staff								
Executive Management	All Other Non-Executive Management Staff								
Sub-Contractors	List all Sub-Contractors								
All Categories	Total								

Note:

1. Description of expenditures or itemized by line item/category  
may be requested by the Department.



## **MCO Program Integrity Requirements**

### **I. Organization**

- A. An MCO's Program Integrity Unit (PIU) shall be organized so that:
1. Required Fraud, Waste and Abuse activities shall be conducted by staff that shall have sufficient authority to direct PIU activities; and shall include written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state regulations and standards;
  2. The unit shall be able to establish, control, evaluate and revise Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure their compliance with Federal and State requirements;
  3. Adequate staff shall be assigned to the PIU to enable them to conduct the functions specified in this Appendix on a continuous and on-going basis and staffing shall consist of a compliance officer, auditing and clinical staff;
  4. The unit shall be able to prioritize work coming into the unit to ensure that cases with the greatest potential program impact are given the highest priority. Allegations or cases having the greatest program impact include cases involving:
    - Multi-State fraud or problems of national scope, or Fraud or Abuse crossing service area boundaries;
    - High dollar amount of potential overpayment; or
    - Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.
  5. MCO shall provide ongoing education to MCO staff on Fraud, Waste and abuse trends including CMS initiatives;
  6. MCO shall attend any training given by the Commonwealth/Fiscal Agent or other MCO's organizations provided reasonable advance notice is given to MCO of the scheduled training.

### **II. Function**

The MCO shall establish a PIU to identify and refer to the Department any suspected Fraud or Abuse of Members and Providers.

- A. The MCO's PIU shall be responsible for:
1. Preventing Fraud, Waste and Abuse by identifying vulnerabilities in the MCO's program including identification of member and provide Fraud, Waste and Abuse by and taking appropriate action including

but not limited to the following:

- Recoupment of overpayments;
  - Changes to policy;
  - Dispute resolution meetings; and
  - Appeals.
2. Proactively detecting incidents of Fraud, Waste and Abuse that exist within the MCO's program through the use of algorithm, investigations and record reviews;
  3. Determining the factual basis of allegations through investigation concerning fraud or abuse made by Members, Providers and other sources;
  4. Initiating appropriate administrative actions to collect overpayments, deny or suspend payments that should not be made;
  5. Referring potential Fraud, Waste and Abuse cases to the OIG (and copying DMS) for preliminary investigation and possible referral for civil and criminal prosecution and administrative sanctions;
  6. Initiating and maintaining network and outreach activities to ensure effective interaction and exchange of information with all internal components of the MCO as well as outside groups;
  7. Making and receiving recommendations to enhance the MCO's ability to prevent, detect and deter Fraud, Waste or Abuse;
  8. Providing prompt response to detected offenses and developing corrective action initiatives relating to the MCO;
  9. Providing for internal monitoring and auditing of MCO and its subcontractors; and supply the department with quarterly reports on the activity and ad hocs as necessary;
  10. Being subject to on-site review and fully complying with requests from the department to supply documentation and records; and
  11. Creating an account receivables process to collect outstanding debt from members or providers and providing monthly reports of activity and collections to the department.

B. The MCO's PIU shall:

1. Conduct continuous and on-going reviews of all MIS data including, Member and Provider Grievances and appeals, for the purpose of identifying potentially fraudulent acts;
2. Conduct regularly scheduled post-payment audits of provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the MCO, the Department and OIG;
3. Conduct onsite and desk audits of providers and report the results to the Department, including any overpayments identified;
4. Maintain locally cases under investigation for possible Fraud, Waste or Abuse activities and provide these lists and entire case

- files to the Department and OIG upon demand;
5. Designate a contact person to work with investigators and attorneys from the Department and OIG;
  6. Ensure the integrity of PIU referrals to the Department. Referrals if appropriate by the unit shall not be subject to the approval of the MCO's management or officials;
  7. Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by providers were received by randomly selecting a minimum sample of 500 claims on a monthly basis;
  8. Run algorithms on claims data and develop a process and report quarterly to the department all algorithms run, issues identified, actions taken to address those issues and the overpayments collected;
  9. Have a method for collecting administratively on member overpayments that were declined prosecution, known as Medicaid Program Violations (MPV) letters, and recover payments from the member;
  10. Comply with the program integrity requirements set forth in 42 CFR 438.608 and provide policies and procedures to the Department for review;
  11. Report any provider denied enrollment by MCO for any reason, including those contained in 42 CFR 455.106, to the Department within 5 days of the enrollment denial;
  12. Have a method for recovering overpayments from providers;
  13. Comply with the program integrity requirements of the Patient Protection and Affordable Care Act as directed by the Department;
  14. Correct any weaknesses, deficiencies, or noncompliance items that are identified as a result of a review or audit conducted by DMS, CMS, or by any other State or Federal Agency that has oversight of the Medicaid program. Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by Federal and state laws and regulations; and
  15. Work cooperatively and collaboratively with the Department to enhance the MCO's PIU and to address any deficiencies identified.

### **III. Patient Abuse**

Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law and carbon copy the Department for Medicaid Services and OIG.

### **IV. Complaint System**

The MCO's PIU shall operate a process to receive, investigate and track the status of Fraud, Waste and Abuse complaints received from members, providers and all other sources which may be made against the MCO, providers or members.

A. The process shall contain the following:

1. Upon receipt of a complaint or other indication of potential fraud or abuse, the MCO's PIU shall conduct a preliminary inquiry to determine the validity of the complaint;
2. The PIU should review background information and MIS data; however, the preliminary inquiry should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;
3. Should the preliminary inquiry result in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to OIG; however, the PI should take whatever actions may be necessary, up to and including, administrative recovery of identified overpayments;
4. Should the preliminary inquiry result in a reasonable belief that Fraud or Abuse has occurred, the PI should refer the case and all supporting documentation to the Department, with a copy to OIG;
5. OIG will review the referral and attached documentation and make a determination as to whether OIG will investigate the case or return it to the PIU for them to conduct a preliminary investigation;
6. OIG will notify the PIU in a timely manner as to whether the OIG will investigate or whether the PIU should conduct a preliminary investigation;
7. If in the process of conducting a preliminary investigation the PIU suspects a violation of either criminal Medicaid fraud statutes or the Federal False Claims Act, the PIU shall immediately notify the Department with a copy to the OIG of their findings and proceed only in accordance with instructions received from the OIG;
8. If OIG determines that it will keep a case referred by the PIU, the OIG will conduct an investigation, gather evidence, write a report and forward information to Department and the PIU for appropriate actions;
9. If OIG opens an investigation based on a complaint received from a source other than the MCO, OIG will, upon completion of the investigation, provide a copy of the investigative report to DMS and the PIU for appropriate actions;
10. If OIG investigation results in a referral to the Attorney General's Medicaid Fraud Control Unit and/or the U.S. Attorney, the OIG will notify DMS and the PIU of the referral. DMS and the PIU should only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;
11. Upon approval of the Department, MCO shall suspend provider

payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;

12. Upon completion of the PIU's preliminary investigation, the PIU should provide the Department and OIG a copy of their investigative report, which should contain the following elements:
  - Name and address of subject;
  - Medicaid identification number;
  - Source of complaint;
  - The complaint/allegation;
  - Date assigned to the investigator;
  - Name of investigator;
  - Date of completion;
  - Methodology used during investigation;
  - Facts discovered by the investigation as well as the full case report and supporting documentation;
  - All exhibits or supporting documentation;
  - Recommendations as considered necessary, for administrative action or policy revision;
  - Overpayment identified, if any, and recommendation concerning collection;
13. The MCO's PIU shall provide OIG and DMS a quarterly member and provider status report of all cases including actions taken to implement recommendations and collection of overpayments;
14. The MCO's PIU shall maintain access to a follow-up system, which can report the status of a particular complaint or grievance process or the status of a specific recoupment; and
15. The MCO's PIU shall assure a Grievance and appeal process for Members and Providers in accordance with 907 KAR 1:671 and 907 KAR 1:563.

## **V. Reporting**

The MCO's PIU shall provide a quarterly in narrative report format all activities and processes for each investigative case (from opening to closure) to the Department within 30 calendar days of investigation closure.

If any internal component of the MCO discovers or is made aware of an incident of possible Member or Provider Fraud, Waste or Abuse, the incident shall be immediately reported to the PIU Coordinator.

The MCO's PIU shall report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and OIG.

- A. The MCO is required to report the following data elements to the

Department and the OIG on a quarterly basis, in an excel format:

1. PIU Case number;
2. OIG Case Number;
3. Provider /Member name;
4. Provider/Member number;
5. Date complaint received by MCO;
6. Source of complaint,-unless the complainant prefers to remain anonymous
7. Date opened;
8. Summary of Complaint;
9. Is complaint substantiated or not substantiated (Y or N answer only under this column),
10. PIU Action Taken (only provide the most current update);
11. Amount of overpayment (if any);
12. Administrative actions taken to resolve findings of completed cases including the following information:
  - The overpayment required to be repaid and overpayment collected to date;
  - Describe sanctions/withholds applied to Providers/Members, if any;
  - Provider/Members appeal regarding overpayment or requested sanctions. If so, list the date an appeal was requested, date the hearing was held, the date of the final decision, and to the extent they have occurred;
  - Revision of the MCO's policies to reduce potential risk from similar situations with a description of the policy recommendation, implemented of aforementioned revision and date of implementation; and
  - Make MIS system edit and audit recommendations as applicable.

## **VI. Availability and Access to Data**

### **A. The MCO shall:**

1. Gather, produce, keep and maintain records including, but not limited to, ownership disclosure, for all providers and subcontractors, submissions, applications, evaluations, qualifications, member information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding letters and subcontracts for a period of 5 years after contract end date;
2. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department, and the OIG;
3. Backup, store and be able to recreate reported data upon demand for the Department and the OIG;
4. Permit reviews, investigations or audits of all books, records or

other data, at the discretion of the Department or OIG, or other authorized federal or state agency; and shall provide access to MCO records and other data on the same basis and at least to the same extent that the Department would have access to those same records;

5. Produce records in electronic format for review and manipulation by the Department and the OIG;
6. Allow designated Department staff read access to ALL data in the MCO's MIS systems; and
7. Provide all contracted rates for providers upon request.

The MCO's PIU shall have access to any and all records and other data of the MCO for purposes of carrying out the functions and responsibilities specified in this section.

The MCO shall fully cooperate with the OIG, the United States Attorney's Office and other law enforcement agencies in the investigation of fraud or abuse cases.

In the event no action toward collection of overpayments is taken by the MCO after one hundred and eight (180) days the Commonwealth may begin collection activity and shall retain any overpayments collected. If the MCO shall takes appropriate action to collect overpayments, the Commonwealth will not intervene.

The MCO shall provide identity and cover documents and information for law enforcement investigators under cover.

## Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule \*

### Infancy

- 3 to 5 days
- < 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months

### Early Childhood

- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- 4 years

### Middle Childhood

- 5 years
- 6 years
- 7 years
- 8 years
- 9 years
- 10 years

### Adolescence

- 11 years
- 12 years
- 13 years
- 14 years
- 15 years
- 16 years
- 17 years
- 18 years
- 19 years
- 20 years

\* EPSDT Periodicity Schedule is based on American Academy Pediatric Guidelines and is subject to change with these guidelines.

**Early and Periodic Screening, Diagnosis and Treatment  
Required Components - Initial and Periodic Health Assessments**

**Health History:**

Complete History Initial Visit  
Interval History Each Visit

**By History /Physical Exam:**

Developmental Assessment Each Visit  
(Age appropriate physical and mental health milestones)  
Nutritional Assessment Each Visit  
Lead Exposure Assessment 6 mo. through 6 yr. age visits

**Physical Exam:**

Complete/ Unclothed Each Visit  
Growth Chart Each Visit  
Vision Screen Assessed each visit  
\*According to recommended medical standards (AAP1)  
Hearing Screen Assessed Each Visit  
\*According to recommended medical standards (AAP1)

**Laboratory:**

Hemoglobin/ Hematocrit \*According to recommended medical standards (AAP1)  
Urinalysis \*According to recommended medical standards (AAP1)  
Lead Blood Level (Low Risk History) 12 mo. and 2 year age visit  
Lead Blood Level (High Risk History) Immediately  
Cholesterol Screening \*According to recommended medical standards (AAP1)  
Sickle Cell Screening Documentation X 1  
Hereditary/ Metabolic Screening \* According to Kentucky statute  
(Newborn Screening)  
Sexually Transmitted Disease Screening \*According to recommended medical standards (AAP1)  
Pelvic Exam (pap smear) \* According to recommended medical standards (AAP1)

**Immunizations:**

DPT Assessed Each Visit  
DTaP \* According to recommended. OPV medical standards (AAP1, ACIP2, Hepatitis BAAFP3)

HiB

MMR

Varicella

Td

PPD

**Health Education/ Anticipatory Guidance**

(Age Appropriate)

Each Visit

**Dental Referral**

Age 1

1. AAP American Academy of Pediatrics  
(Committee on Practice and Ambulatory Medicine)
2. ACIP Advisory Committee on Immunization Practices
3. AAFP American Academy of Family Physicians

EPSDT provides any Medically Necessary diagnosis and treatment for Members under the age of 21 indicated as the result of an EPSDT health assessment or any other encounter with a licensed or certified health care professional, even if the service is not otherwise covered by the Kentucky Medicaid Program. These services which are not otherwise covered by the Kentucky Medicaid Program are called EPSDT Special Services.

The Contractor shall provide EPSDT Special Services as required by 42 USC Section 1396 and by 907 KAR 1:034, Section 7 and Section 8.

The Contractor shall provide the following medically necessary health care, diagnostic services, preventive services, rehabilitative services, treatment and other measures, described in 42 USC Section 1396d(a), to all members under the age of 21:

- (a) Inpatient Hospital Services;
- (b) Outpatient Services; Rural Health Clinics; Federally Qualified Health Center Services;
- (c) Other Laboratory and X-Ray Services;
- (d) Early and Periodic Screening, Diagnosis, and Treatment Services; Family Planning Services and Supplies;
- (e) Physicians Services; Medical and Surgical Services furnished by a Dentist;
- (f) Medical Care by Other Licensed Practitioners;
- (g) Home Health Care Services;
- (h) Private Duty Nursing Services;
- (i) Clinic Services;
- (j) Dental Services;

- (k) Physical Therapy and Related Services;
- (l) Prescribed Drugs including Mental/Behavioral Health Drugs, Dentures, and Prosthetic Devices; and Eyeglasses;
- (m) Other Diagnostic, Screening, Preventive and Rehabilitative Services;
- (n) Nurse-Midwife Services;
- (o) Hospice Care;
- (p) Case Management Services;
- (q) Respiratory Care Services;
- (r) Services provided by a certified pediatric nurse practitioner or certified family; Nurse practitioner (to the extent permitted under state law);
- (s) Other Medical and Remedial Care Specified by the Secretary; and
- (t) Other Medical or Remedial Care Recognized by the Secretary but which are not covered in the Plan Including Services of Christian Science Nurses, Care and Services Provided in Christian Science Sanitariums, and Personal Care Services in a Recipient's Home.

Those EPSDT diagnosis and treatment services and EPSDT Special Services which are not otherwise covered by the Kentucky Medicaid Program shall be covered subject to Prior Authorization by the Contractor, as specified in 907 KAR 1:034, Section 9. Approval of requests for EPSDT Special Services shall be based on the standard of Medical Necessity specified in 907 KAR 1:034, Section 9.

The Contractor shall be responsible for identifying Providers who can deliver the EPSDT special services needed by Members under the age of 21, and for enrolling these Providers into the Contractor's Network, consistent with requirements specified in this Contract.

## Third Party Liability/Coordination of Benefits Requirements

I. To meet the requirements of 42 CFR 433.138 through 433.139, the Contractor shall be responsible for:

A. Maintaining an MIS that includes:

1. Third Party Liability Resource File

- Policy Begin Date
- Policy End Date
- Policyholder Name
- Policyholder Address
- Insurance Company Name
- Insurance Company Address
- Type of Coverage
- Policy Type
- HIC Number

- a) Cost Avoidance - Use automated daily and monthly TPL files to update the Contractor's MIS TPL files as appropriate. This information is to cost avoid claims for members who have other insurance.
- b) DMS shall require the Contractor to do data matches with insurers. DMS shall require the Contractor to obtain subscriber data and perform data matches with a specified list of insurance companies, as defined by DMS.
- c) Department for Community Based Services (DCBS) - Apply Third Party Liability (TPL) information provided electronically on a daily basis by DMS through its contract with DCBS to have eligibility caseworkers collect third party liability information during the Recipient application process and reinvestigation process.
- d) Workers' Compensation -. The data is provided electronically on a quarterly basis by DMS to the Contractor. This data should be applied to TPL files referenced in I.A.1.a (Commercial Data Matching) in this Appendix.

2. Third Party Liability Billing File

- MAID
- TCN
- Policy#
- Carrier Billed
- Amount Paid
- Amount Billed
- Amount Received

- TCN Status Code (Code identifies if claim was denied and the reason for the denial)
  - Billing Type (Code identifies claim was billed to insurance policy)
  - Date Billed
  - Date Paid or Denied
  - Date Rebilled
- a) Commercial Insurance/Medicare Part B Billing - The Contractor's MIS should automatically search paid claim history and recover from providers, insurance companies or Medicare Part B in a nationally accepted billing format for all claim types whenever other commercial insurance or Medicare Part B coverage is discovered and added to the Contractor's MIS that was unknown to the Contractor at the time of payment of a claim or when a claim could not be cost avoided due to federal regulations (pay and chase) which should have been paid by the health plan. Within sixty (60) Days from the date of identification of the other third party resource billings must be generated and sent to liable parties.
- b) Medicare Part A - The Contractor's MIS should automatically search paid claim history and generate reports by Provider of the billings applicable to Medicare Part A coverage whenever Medicare Part A coverage is discovered and added to the Contractor's MIS that was unknown to the Contractor at the time of payment of a claim. Providers who do not dispute the Medicare coverage should be instructed to bill Medicare immediately. The Contractor's MIS should recoup the previous payment from the Provider within sixty (60) days from the date the reports are sent to the Providers, if they do not dispute that Medicare coverage exists.
- c) Manual Research/System Billing - System should include capability for the manual setup for billings applicable to workers' compensation, casualty, absent parents and other liability coverage that require manual research to determine payable claims.

### 3. Questionnaire File

- MAID
- Where it was sent
- Type of Questionnaire Sent
- Date Sent
- Date Followed Up
- Actions Taken

All questionnaires should be tracked in a Questionnaire history file on the MIS.

B. Coordination of Third Party Information (COB)

1. Division of Child Support Enforcement (DCSE)

Provide county attorneys and the Division of Child Support Enforcement (DCSE) upon request with amounts paid by the Contractor in order to seek restitution for the payment of past medical bills and to obtain insurance coverage to cost avoid payment of future medical bills.

2. Casualty Recoveries

Actively pursue recovery from carriers or members with settlements. Contractor shall provide the necessary information regarding paid claims to necessary parties in order to seek recovery from liable parties in legal actions involving Members.

Notify DMS with information regarding casualty or liability insurance (i.e. auto, homeowner's, malpractice insurance, etc.) when lawsuits are filed and attorneys are retained as a result of tort action. This information should be referred in writing within five (5) working Days of identifying such information.

In cases where an attorney has been retained, a lawsuit filed or a lump sum settlement offer is made, the Contractor shall notify Medicaid within five days of identifying such information so that recovery efforts can be coordinated and monthly through a comprehensive report.

C. Claims

1. Processing

a) Contractor MIS edits:

- Edit and cost avoid Claims when Member has Medicare coverage;
- Edit and cost avoid Claims when Provider indicates other insurance on claim but does not identify payment or denial from third party;
- Edit and cost avoid Claims when Provider indicates services provided were work related and does not indicate denial from workers' compensation carrier;
- Edit and cost avoid or pay and chase as required by

federal regulations when Member has other insurance coverage. When cost avoiding, the Contractor's MIS should supply the Provider with information on the remittance advice that would be needed to bill the other insurance, such as carrier name, address, policy #, etc.;

- Edit Claims as required by federal regulations for accident/trauma diagnosis codes. Claims with the accident/trauma diagnosis codes should be flagged and accumulated for ninety (90) Days and if the amount accumulated exceeds \$250, a questionnaire should be sent to the Member in an effort to identify whether other third party resources may be liable to pay for these medical bills;
- The Contractor is prohibited from cost avoiding Claims when the source of the insurance coverage was due to a court order. All Claims with the exception of hospital Claims must be paid and chased. Hospital claims may be cost avoided; and
- A questionnaire should be generated and mailed to Members and/or Providers for claims processed with other insurance coverage indicated on the claim and where no insurance coverage is indicated on the Contractor's MIS Third Party Files.

2. Encounter Record
  - a) TPL Indicator
  - b) TPL Payment

II. DMS shall be responsible for the following:

- A. Provide the Contractor with an initial third party information proprietary file;
- B. Provide, through a proprietary data file, copies of insurance company's subscriber eligibility files that are received by DMS;
- C. Provide proprietary data files of third party information transmitted from DCBS;
- D. Ensuring the Contractors obtain a data match file from the Labor Cabinet on a quarterly basis;
- E. Provide the Contractor with a list of the Division of Child Support Contracting Officials.
- F. Ensure coordination of calls from attorneys to the Contractor in order for their Claims to be included in casualty settlements; and
- G. Monitoring Encounter Claims and reports submitted by the Contractor to ensure that the Contractor performs all required activities.

## Management Information Systems Requirements

As specified in Management Information Systems Section in the Contract, The Contractor's MIS must enable the Contractor to provide format and file specifications for all data elements as specified below for all of the required seven subsystems.

### I. Member Subsystem

#### A. Inputs

The Recipient Data Maintenance function will accept input from various sources to add, change, or close records on the file(s). Inputs to the Recipient Data Maintenance function include:

1. Daily and monthly electronic member eligibility updates (HIPAA ASC X12 834)
2. Claim/encounter history – sequential file; file description to be determined
3. Social demographic information
4. Initial Implementation of the Contract, the following inputs shall be provide to the contractor:
  - Initial Member assignment file (sequential file; format to be supplemented at contract execution); a file will be sent approximately sixty (60) calendar days prior to the Contractor effective date of operations
  - Member claim history file – twelve (12) months of member claim history (sequential file; format to be supplemented at Contract execution)
  - Member Prior Authorizations in force file (medical and pharmacy; sequential file; format will be supplemented at Contract execution)

#### B. Processing Requirements

The Recipient Data Maintenance function must include the following capabilities:

1. Accept a daily/monthly member eligibility file from the Department in a specified format.
2. Transmit a file of health status information to the Department in a specified format.
3. Transmit a file of social demographic data to the Department in a specified format.
4. Transmit a primary care provider (PCP) enrollment file to the Department in a specified format.
5. Edit data transmitted from the Department for completeness and consistency, editing all data in the transaction.
6. Identify potential duplicate Member records during update processing.
7. Maintain on-line access to all current and historical Member

information, with inquiry capability by case number, Medicaid Recipient ID number, social security number (SSN), HIC number, full name or partial name, and the ability to use other factors such as date of birth and/or county code to limit the search by name.

8. Maintain identification of Member eligibility in special eligibility programs, such as hospice, etc., with effective date ranges/spans and other data required by the Department.
9. Maintain current and historical date-specific managed care eligibility data for basic program eligibility, special program eligibility, and all other Member data required to support Claims processing, Prior Authorization processing, managed care processing, etc.
10. Maintain and display the same values as the Department for eligibility codes and other related data.
11. Produce, issue and mail a managed care ID card pursuant to the Department's approval within Department determined time requirements.
12. Identify Member changes in the primary care provider (PCP) and the reason(s) for those changes to include effective dates.
13. Monitor PCP capacity and limitations prior to Enrollment of a Member to the PCP.
14. Generate and track PCP referrals.
15. Assign applicable Member to PCP if one is not selected within thirty (30) Days, except Members with SSI without Medicare, who are allowed ninety (90) Days.

C. Reports

Reports for Member function are described in Appendix XI.

D. On-line Inquiry Screens

On-line inquiry screens that meet the user interface requirements of this section and provide access to the following data:

1. Member basic demographic data
2. Member liability data
3. Member characteristics and service utilization data
4. Member current and historical managed care eligibility data
5. Member special program data
6. Member social/demographic data
7. Health status data
8. PCP data

E. Interfaces

The Member Data Maintenance function must accommodate an external electronic interface (HIPAA ASC X12 834, both 4010A1 and 5010 after January 1, 2012) with the Department.

## II. Third Party Liability (TPL) Subsystem

The Third Party Liability (TPL) processing function permits the Contractor to utilize the private health, Medicare, and other third-party resources of its Members and ensures that the Contractor is the payer of last resort. This function works through a combination of cost avoidance (non-payment of billed amounts for which a third party may be liable) and post-payment recovery (post-payment collection of Contractor paid amounts for which a third party is liable).

Cost avoidance is the preferred method for processing claims with TPL. This method is implemented automatically by the MIS through application of edits and audits which check claim information against various data fields on recipient, TPL, reference, or other MIS files. Post-payment recovery is primarily a back-up process to cost avoidance, and is also used in certain situations where cost avoidance is impractical or unallowable.

The TPL information maintained by the MIS must include Member TPL resource data, insurance carrier data, health plan coverage data, threshold information, and post payment recovery tracking data. The TPL processing function will assure the presence of this information for use by the Edit/Audit Processing, Financial Processing, and Claim Pricing functions, and will also use it to perform the functions described in this subsection for TPL Processing.

**A. Inputs**

The following are required inputs to the TPL function of the MIS:

1. Member eligibility, Medicare, and TPL, information from the Department via proprietary file formats.
2. Enrollment and coverage information from private insurers/health plans, state plans, and government plans.
3. TPL-related data from claims, claim attachments, or claims history files, including but not limited to:
  - diagnosis codes, procedure codes, or other indicators suggesting trauma or accident;
  - indication that a TPL payment has been made for the claim (including Medicare);
  - indication that the Member has reported the existence of TPL to the Provider submitting the claim;
  - indication that TPL is not available for the service claimed.
4. Correspondence and phone calls from Members, carriers, and Providers and DMS.

**B. Processing Requirements**

The TPL processing function must include the following capabilities:

1. Maintain accurate third-party resource information by Member including but not limited to:
  - Name, ID number, date of birth, SSN of eligible Member;
  - Policy number or Medicare HIC number and group number;

- Name and address of policyholder, relationship to Member,
  - SSN of policyholder;
  - Court-ordered support indicator;
  - Employer name and tax identification number and address of policyholder;
  - Type of policy, type of coverage, and inclusive dates of coverage;
  - Date and source of TPL resource verification; and
  - Insurance carrier name and tax identification and ID.
1. Provide for multiple, date-specific TPL resources (including Medicare) for each Member.
  2. Maintain current and historical information on third-party resources for each Member.
  3. Maintain third-party carrier information that includes but is not limited to:
    - Carrier name and ID
    - Corporate correspondence address and phone number
    - Claims submission address(s) and phone number
  1. Identify all payment costs avoided due to established TPL, as defined by the Department.
  2. Maintain a process to identify previously paid claims for recovery when TPL resources are identified or verified retroactively, and to initiate recovery within sixty (60) Days of the date the TPL resource is known to the Contractor.
  3. Maintain an automated tracking and follow-up capability for all TPL questionnaires.
  4. Maintain an automated tracking and follow-up capability for post payment recovery actions which applies to health insurance, casualty insurance, and all other types of recoveries, and which can track individual or group claims from the initiation of recovery efforts to closure.
  5. Provide for the initiation of recovery action at any point in the claim processing cycle.
  6. Maintain a process to adjust paid claims history for a claim when a recovery is received.
  7. Provide for unique identification of recovery records.
  8. Provide for on-line display, inquiry, and updating of recovery case records with access by claim, Member, carrier, Provider or a combination of these data elements.
  9. Accept, edit and update with all TPL and Medicare information received from the Department through the Member eligibility update or other TPL updates specified by the Department.
  10. Implement processing procedures that correctly identify and cost avoid claims having potential TPL, and flag claims for future recovery to the appropriate level of detail.
  11. Provide verified Member TPL resource information generated from

data matches and claims; to the Department for Medicaid Services, in an agreed upon format and media, on a monthly basis.

C. Reports

The following types of reports must be available from the TPL Processing function by the last day of the month for the previous month:

1. Cost-avoidance summary savings reports, including Medicare but identifying it separately;
2. Listings and totals of cost-avoided claims;
3. Listings and totals of third-party resources utilized;
4. Reports of amounts billed and collected, current and historical, from the TPL recovery tracking system, by carrier and Member;
5. Detailed aging report for attempted recoveries by carrier and Member;
6. Report on the number and amount of recoveries by type; for example, fraud collections, private insurance, and the like;
7. Report on the unrecoverable amounts by type and reason, carrier, and other relevant data, on an aged basis and in potential dollar ranges;
8. Report on the potential trauma and/or accident claims for claims that meet specified dollar threshold amounts;
9. Report on services subject to potential recovery when date of death is reported;
10. Unduplicated cost-avoidance reporting by program category and by type of service, with accurate totals and subtotals;
11. Listings of TPL carrier coverage data;
12. Audit trails of changes to TPL data.

D. On-line Inquiry Screens

On-line inquiry screens that meet the user interface requirements of this section and provide the following data:

1. Member current and historical TPL data
2. TPL carrier data
3. Absent parent data
4. Recovery cases

Automatically generate letters/questionnaires to carriers, employers, Members, and Providers when recoveries are initiated, when TPL resource data is needed, or when accident information is required and was not supplied with the incoming claim.

Automatically generate claim facsimiles, which can be sent to carriers, attorneys, or other parties.

Provide absent parent canceled court order information generated from data matches with the Division of Child Support Enforcement, to the

Department, in an agreed upon format and media, on an annual basis.

### **III. Provider Subsystem**

The provider function accepts and maintains comprehensive, current and historical information about Providers eligible to participate in the Contractor's Network. The maintenance of provider data is required to support Claims and Encounter processing, utilization/quality processing, financial processing and report functions. The Contractor will be required to electronically transmit provider enrollment information to the Department as requested.

#### **A. Inputs**

The inputs to the provider Data Maintenance function include:

1. Provider update transactions
2. Licensure information, including electronic input from other governmental agencies
3. Financial payment, adjustment, and accounts receivable data from the Financial Processing function.

#### **B. Processing Requirements**

The Provider Data Maintenance function must have the capabilities to:

1. Transmit a provider enrollment file to the Department in a specified format;
2. Maintain current and historical provider enrollment applications from receipt to final disposition (approval only);
3. Maintain on-line access to all current and historical provider information, including Provider rates and effective dates, Provider program and status codes, and summary payment data;
4. Maintain on-line access to Provider information with inquiry by Provider name, partial name characters, provider number, NPI, SSN, FEIN, CLIA number, Provider type and specialty, County, Zip Code, and electronic billing status;
5. Edit all update data for presence, format, and consistency with other data in the update transaction;
6. Edits to prevent duplicate Provider enrollment during an update transaction;
7. Accept and maintain the Medicare Universal Provider Identification Number (UPIN);
8. Provide a Geographic Information System (GIS) to identify Member populations, service utilization, and corresponding Provider coverage to support the Provider recruitment, enrollment, and participation;
9. Maintain on-line audit trail of Provider names, Provider numbers (including old and new numbers, NPI), locations, and status changes by program;

10. Identify by Provider any applicable type code, NPI/TAXONOMY code, location code, practice type code, category of service code, and medical specialty and sub-specialty code which is used in the Kentucky Medicaid program, and which affects Provider billing, claim pricing, or other processing activities;
11. Maintain effective dates for Provider membership, Enrollment status, restriction and on-review data, Not sure what this means certification(s), specialty, sub-specialty, claim types, and other user-specified Provider status codes and indicators;
12. Accept group provider numbers, and relate individual Providers to their groups, as well as a group to its individual member Providers, with effective date ranges/spans. A single group provider record must be able to identify an unlimited number of individuals who are associated with the group;
13. Maintain multiple, provider-specific reimbursement rates, including, but not necessarily limited to, per diems, case mix, rates based on licensed levels of care, specific provider agreements, volume purchase contracts, and capitation, with beginning and ending effective dates for a minimum of sixty (60) months.
14. Maintain provider-specific rates by program, type of capitation, Member program category, specific demographic classes, Covered Services, and service area for any prepaid health plan or managed care providers;
15. Provide the capability to identify a Provider as a PCP and maintain an inventory of available enrollment slots;
16. Identify multiple practice locations for a single provider and associate all relevant data items with the location, such as address and CLIA certification;
17. Maintain multiple addresses for a Provider, including but not limited to:
  - Pay to;
  - Mailing, and
  - Service location(s).
18. Create, maintain and define provider enrollment status codes with associated date spans. For example, the enrollment codes must include but not be limited to:
  - Application pending
  - Limited time-span enrollment
  - Enrollment suspended
  - Terminated-voluntary/involuntary
19. Maintain a National Provider Identifier (NPI) and taxonomies;
20. Maintain specific codes for restricting the services for which Providers may bill to those for which they have the proper certifications (for example, CLIA certification codes);
21. Maintain summary-level accounts receivable and payable data in the provider file that is automatically updated after each payment

- cycle;
22. Provide the capability to calculate and maintain separate 1099 and associated payment data by FEIN number for Providers with changes of ownership, based upon effective dates entered by the Contractor;
  23. Generate a file of specified providers, selected based on the Department identified parameters, in an agreed upon Department approved format and media, to be provided to the Department on an agreed upon periodic basis; and
  24. Generate a file of provider 1099 information.
  25. Reports – Reports for Provider functions are as described in Appendices s K and L.

C. **On-line Inquiry Screens**

On-line inquiry screens that meet the user interface requirements of this contract and provide access to the following data:

1. Provider eligibility history
2. Basic information about a Provider (for example, name, location, number, program, provider type, specialty, sub-specialty, certification dates, effective dates)
3. Provider group inquiry, by individual provider number displaying groups and by group number displaying individuals in group (with effective and end dates for those individuals within the group)
4. Provider rate data
5. Provider accounts receivable and payable data, including claims adjusted but not yet paid
6. Provider Medicare number(s) by Medicare number, Medicaid number, and SSN/FEIN
7. Demographic reports and maps from the GIS, for performing, billing, and/or enrolled provider, listing provider name, address, and telephone number to assist in the provider recruitment process and provider relations

D. **Interfaces**

The Provider Data Maintenance function must accommodate an external interface with:

1. The Department; and
2. Other governmental agencies to receive licensure information.

**IV. Reference Subsystem**

The reference function maintains pricing files for procedures and drugs including Mental/Behavioral Health Drugs and maintains other general reference information such as diagnoses and reimbursement parameters/modifiers. The reference function provides a consolidated source of reference information which is accessed by the MIS during performance of other functions, including claims and encounter processing, TPL processing and utilization/quality reporting

functions.

The contractor must maintain sufficient reference data (NDC codes, HCPCS, CPT4, Revenue codes, etc.) to accurately process fee for service claims and develop encounter data for transmission to the Department as well as support Department required reporting.

A. Inputs

The inputs to the Reference Data Maintenance function are:

1. NDC codes
2. CMS - HCPCS updates
3. ICD-9-CM or 10 and DSM III diagnosis and procedure updates
4. ADA (dental) codes

B. Processing Requirements

The Reference Processing function must include the following capabilities:

1. Maintain current and historical reference data, assuring that updates do not overlay or otherwise make historical information inaccessible.
2. Maintain a Procedure data set which is keyed to the five-character HCPCS code for medical-surgical and other professional services, ADA dental codes; a two-character field for HCPCS pricing modifiers; and the Department's specific codes for other medical services; in addition, the procedure data set will contain, at a minimum, the following elements for each procedure:
  - Thirty-six (36) months of date-specific pricing segments, including a pricing action code, effective beginning and end dates, and allowed amounts for each segment.
  - Thirty-six (36) months of status code segments with effective beginning and end dates for each segment.
  - Multiple modifiers and the percentage of the allowed price applicable to each modifier.
  - Indication of TPL actions, such as Cost Avoidance, Benefit Recovery or Pay, by procedure code.
  - Other information such as accident-related indicators for possible TPL, federal cost-sharing indicators, Medicare coverage and allowed amounts.
3. Maintain a diagnosis data set utilizing the three (3), four (4), and five (5) character for ICD-9-CM and 7 digits for ICD-10 and DSM III coding system, which supports relationship editing between diagnosis code and claim information including but not limited to:
  - Valid age
  - Valid sex
  - Family planning indicator
  - Prior authorization requirements

- EPSDT indicator
  - Trauma diagnosis and accident cause codes
  - Description of the diagnosis
  - Permitted primary and secondary diagnosis code usage
4. Maintain descriptions of diagnoses.
  5. Maintain flexibility in the diagnosis file to accommodate expanded diagnosis codes with the implementation of ICD-10 by October 1, 2013.
  6. Maintain a drug data set of the eleven (11) digit National Drug Code (NDC), including package size, which can accommodate updates from a drug pricing service and the CMS Drug Rebate file updates; the Drug data set must contain, at a minimum:
    - Unlimited date-specific pricing segments that include all prices and pricing action codes needed to adjudicate drug claims.
    - Indicator for multiple dispensing fees
    - Indicator for drug rebate including name of manufacturer and labeler codes.
    - Description and purpose of the drug code.
    - Identification of the therapeutic class.
    - Identification of discontinued NDCs and the termination date.
    - Identification of CMS Rebate program status.
    - Identification of strength, units, and quantity on which price is based.
    - Indication of DESI status (designated as less than effective), and IRS status (identical, related or similar to DESI drugs).
  7. Maintain a Revenue Center Code data set for use in processing claims for hospital inpatient/outpatient services, home health, hospice, and such.
  8. Maintain flexibility to accommodate multiple reimbursement methodologies, including but not limited to fee-for-service, capitation and carve-outs from Capitated or other "all inclusive" rate systems, and DRG reimbursement for inpatient hospital care, etc.
  9. Maintain pricing files based on:
    - Fee schedule
    - Per DIEM rates
    - Capitated rates
    - Federal maximum allowable cost (FMAC), estimated acquisition (EAC) for drugs
    - Percentage of charge allowance
    - Contracted amounts for certain services
    - Fee schedule that would pay at variable percentages.
    - (MAC) Maximum allowable cost pricing structure

### C. On-line Inquiry Screens

Maintain on-line access to all Reference files with inquiry by the appropriate service code, depending on the file or table being accessed.

Maintain on-line inquiry to procedure and diagnosis files by name or description including support for phonetic and partial name search.

Provide inquiry screens that display:

- All relevant pricing data and restrictive limitations for claims processing including historical information, and
- All pertinent data for claims processing and report generation.

**D. Interfaces**

The Reference Data Maintenance function must interface with:

1. ADA (dental) codes
2. CMS-HCPCS updates;
3. ICD-9, ICD-10, DSM, or other diagnosis/surgery code updating service; and
4. NDC Codes.

**I. Financial Subsystem**

The financial function encompasses claim payment processing, adjustment processing, accounts receivable processing, and all other financial transaction processing. This function ensures that all funds are appropriately disbursed for claim payments and all post-payment transactions are applied accurately. The financial processing function is the last step in claims processing and produces remittance advice statements/explanation of benefits and financial reports.

**A. Inputs**

The Financial Processing function must accept the following inputs:

1. On-line entered, non-claim-specific financial transactions, such as recoupments, mass adjustments, cash transactions, etc;
2. Retroactive changes to Member financial liability and TPL retroactive changes from the Member data maintenance function;
3. Provider, Member, and reference data from the MIS.

**B. Processing Requirements**

The MIS must perform three types of financial processing: 1) payment processing; 2) adjustment processing; 3) other financial processing.

Required system capabilities are classified under one of these headings in this subsection.

**C. Payment Processing**

Claims that have passed all edit, audit, and pricing processing, or which have been denied, must be processed for payment by the Contractor if the

contractor has fee for service arrangements. Payment processing must include the capability to:

1. Maintain a consolidated accounts receivable function and deduct/add appropriate amounts and/or percentages from processed payments.
2. Update individual provider payment data and 1099 data on the Provider database.

D. Adjustment Processing

The MIS adjustment processing function must have the capabilities to:

1. Maintain complete audit trails of adjustment processing activities on the claims history files.
2. Update provider payment history and recipient claims history with all appropriate financial information and reflect adjustments in subsequent reporting, including claim-specific and non claim-specific recoveries.
3. Maintain the original claim and the results of all adjustment transactions in claims history; link all claims and subsequent adjustments by control number, providing for identification of previous adjustment and original claim number.
4. Reverse the amount previously paid/recovered and then processes the adjustment so that the adjustment can be easily identified.
5. Re-edit, re-price, and re-audit each adjustment including checking for duplication against other regular and adjustment claims, in history and in process.
6. Maintain adjustment information which indicates who initiated the adjustment, the reason for the adjustment, and the disposition of the claim (additional payment, recovery, history only, etc.) for use in reporting the adjustment.
7. Maintain an adjustment function to re-price claims, within the same adjudication cycle, for retroactive pricing changes, Member liability changes, Member or provider eligibility changes, and other changes necessitating reprocessing of multiple claims.
8. Maintain a retroactive rate adjustment capability which will automatically identify all Claims affected by the adjustment, create adjustment records for them, reprocess them, and maintain a link between the original and adjusted Claim.

E. Other Financial Processing

Financial transactions such as stop payments, voids, reissues, manual checks, cash receipts, repayments, cost settlements, overpayment adjustments, recoupments, and financial transactions processed outside the MIS are to be processed as part of the Financial Processing function. To process these transactions, the MIS must have the capability to:

1. Maintain the following information:
  - Program identification (for example, TPL recovery, rate

- adjustment);
  - Transaction source (for example, system generated, refund, Department generated);
  - Provider number/entity name and identification number;
  - Payment/recoupment detail (for example, dates, amounts, cash or recoupment);
  - Account balance;
  - Reason indicator for the transaction (for example, returned dollars from provider for TPL, unidentified returned dollars, patient financial liability adjustment);
  - Comment section;
  - Type of collection (for example, recoupment, cash receipt);
  - Program to be affected;
  - Adjustment indicator; and
  - Internal control number (ICN) (if applicable).
2. Accept manual or automated updates including payments, changes, deletions, suspensions, and write-offs, of financial transactions and incorporate them as MIS financial transactions for purposes of updating claims history, Provider/Member history, current month financial reporting, accounts receivable, and other appropriate files and reports.
  3. Maintain sufficient controls to track each financial transaction, balance each batch, and maintain appropriate audit trails on the claims history and consolidated accounts receivable system, including a mechanism for adding user narrative.
  4. Maintain on-line inquiry to current and historical financial information with access by Provider ID or entity identification, at a minimum to include:
    - Current amount payable/due
    - Total amount of claims adjudication for the period
    - Aging of receivable information, according to user defined aging parameters
    - Receivable account balance and established date
    - Percentages and/or dollar amounts to be deducted from future payments
    - Type and amounts of collections made and dates
    - Both non-claim-specific, and
    - Data to meet the Department's reporting.
  5. Maintain a recoupment process that sets up Provider accounts receivable that can be either automatically recouped from claims payments or satisfied by repayments from the provider or both.
  6. Maintain a methodology to apply monies received toward the established recoupment to the accounts receivable file, including the remittance advice date, number, and amount, program, and transfer that data to an on-line provider paid claims summary.

7. Identify a type, reason, and disposition on recoupments, payouts, and other financial transactions.
8. Provide a method to link full or partial refunds to the specific Claim affected, according to guidelines established by the Department.
9. Generate provider 1099 information annually, which indicate the total paid claims plus or minus any appropriate adjustments and financial transactions.
10. Maintain a process to adjust providers' 1099 earnings with payout or recoupment or transaction amounts through the accounts receivable transactions.
11. Maintain a process to accommodate the issuance and tracking of non-provider-related payments through the MIS (for example, a refund or an insurance company overpayment) and adjust expenditure reporting appropriately.
12. Track all financial transactions, by program and source, to include TPL recoveries, Fraud, Waste and Abuse recoveries, provider payments, drug rebates, and so forth.
13. Determine the correct federal fiscal year within claim adjustments and other financial transactions are to be reported.
14. Provide a method to direct payments resulting from an escrow or lien request to facilitate any court order or legal directive received.

C. Reports

Reports from the financial processing function are described in Appendix L and Contractor Reporting Requirements Section of Contract.

## II. Utilization/Quality Improvement

The utilization/quality improvement function combines data from other external systems, such as Geo Network to produce reports for analysis which focus on the review and assessment of access and availability of services and quality of care given, detection of over and under utilization, and the development of user-defined reporting criteria and standards. This system profiles utilization of Providers and Members and compares them against experience and norms for comparable individuals.

This system supports tracking utilization control function(s) and monitoring activities for inpatient admissions, emergency room use, and out-of-area services. It completes Provider profiles, occurrence reporting, monitoring and evaluation studies, and Member/Provider satisfaction survey compilations. The subsystem may integrate the Contractor's manual and automated processes or incorporate other software reporting and/or analysis programs.

This system also supports and maintains information from Member surveys, Provider and Member Grievances, Appeal processes.

A. Inputs

The Utilization/Quality Improvement system must accept the following inputs:

1. Adjudicated Claims/encounters from the claims processing subsystem;
2. Provider data from the provider subsystem;
3. Member data from the Member subsystem.

B. Processing Requirements

The Utilization/Quality Improvement function must include the following capabilities:

1. Maintain Provider credentialing and recredentialing activities.
2. Maintain Contractor's processes to monitor and identify deviations in patterns of treatment from established standards or norms. Provide feedback information for monitoring progress toward goals, identifying optimal practices, and promoting continuous improvement.
3. Maintain development of cost and utilization data by Provider and services.
4. Provide aggregate performance and outcome measures using standardized quality indicators similar to Medicaid HEDIS as specified by the Department.
5. Support focused quality of care studies.
6. Support the management of referral/utilization control processes and procedures.
7. Monitor PCP referral patterns.
8. Support functions of reviewing access, use and coordination of services (i.e. actions of peer review and alert/flag for review and/or follow-up; laboratory, x-ray and other ancillary service utilization per visit).
9. Store and report Member satisfaction data through use of Member surveys, Grievance/Appeals processes, etc.
10. Provide Fraud, Waste and Abuse detection, monitoring and reporting.

C. Reports

Utilization/quality improvement reports are listed in Appendices K and L.

**III. Claims Control and Entry**

The Claims Control function ensures that all claims are captured at the earliest possible time and in an accurate manner. Claims must be adjudicated within the parameters of Prompt Pay standards set by CMS and the American Recovery and Reinvestment Act (ARRA).

**IV. Edit/Audit Processing**

The Edit/Audit Processing function ensures that Claims are processed in accordance with Department and Contractor policy and the development of accurate encounters to be transmitted to the department. This processing includes application of non-history-related edits and history-related audits to the Claim. Claims are screened against Member and Provider eligibility information; pending and paid/denied claims history; and procedure, drug, diagnosis, and edit/audit information. Those Claims that exceed Program limitations or do not satisfy Program or processing requirements, suspend or deny with system assigned error messages related to the Claim.

Claims also need to be edited utilizing all components of the CMS mandated National Correct Coding Initiative (NCCI)

A. Inputs

The inputs to the Edit/Audit Processing function are:

1. The Claims that have been entered into the claims processing system from the claims entry function;
2. Member, Provider, reference data required to perform the edits and audits.

B. Processing Requirements

Basic editing necessary to pass the Claims onto subsequent processing requires that the MIS have the capabilities to:

1. Edit each data element on the Claim record for required presence, format, consistency, reasonableness, and/or allowable values.
2. Edit to assure that the services for which payment is requested are covered.
3. Edit to assure that all required attachments are present.
4. Maintain a function to process all Claims against an edit/audit criteria table and an error disposition file (maintained in the Reference Data Maintenance function) to provide flexibility in edit and audit processing.
5. Edit for prior authorization requirements and to assure that a prior authorization number is present on the Claim and matches to an active Prior Authorization on the MIS.
6. Edit Prior-Authorized claims and cut back billed units or dollars, as appropriate, to remaining authorized units or dollars, including Claims and adjustments processed within the same cycle.
7. Maintain edit disposition to deny Claims for services that require Prior Authorization if no Prior Authorization is identified or active.
8. Update the Prior Authorization record to reflect the services paid on the Claim and the number of services still remaining to be used.
9. Perform relationship and consistency edits on data within a single Claim for all Claims.
10. Perform automated audit processing (e.g., duplicate, conflict, etc.) using history Claims, suspended Claims, and same cycle Claims.

11. Edit for potential duplicate claims by taking into account group and rendering Provider, multiple Provider locations, and across Provider and Claim types.
12. Identify exact duplicate claims.
13. Perform automated audits using duplicate and suspect-duplicate criteria to validate against history and same cycle claims.
14. Perform all components of National Correct Coding Initiative (NCCI) edits
15. Maintain audit trail of all error code occurrences linked to a specific Claim line or service, if appropriate.
16. Edit and suspend each line on a multi-line Claim independently.
17. Edit each Claim record completely during an edit or audit cycle, when appropriate, rather than ceasing the edit process when an edit failure is encountered.
18. Identify and track all edits and audits posted to the claim from suspense through adjudication.
19. Update Claim history files with both paid and denied Claims from the previous audit run.
20. Maintain a record of services needed for audit processing where the audit criteria covers a period longer than thirty-six (36) months (such as once-in-a-lifetime procedures).
21. Edit fields in Appendices D and E for validity (numerical field, appropriate dates, values, etc.).

## **V. Claims Pricing**

The Claims Pricing function calculates the payment amount for each service according to the rules and limitations applicable to each Claim type, category of service, type of provider, and provider reimbursement code. This process takes into consideration the Contractor allowed amount, TPL payments, Medicare payments, Member age, prior authorized amounts, and any co-payment requirements. Prices are maintained on the Reference files (e.g., by service, procedure, supply, drug, etc.) or provider-specific rate files and are date-specific.

The Contractor MIS must process and pay Medicare Crossover Claims and adjustments.

### **A. Inputs**

The inputs into the Claims Pricing function are the Claims that have been passed from the edit/audit process.

The Reference and Provider files containing pricing information are also inputs to this function.

### **B. Processing Requirements**

The Claims Pricing function for those Fee For Service contracts the

vendor has with providers of the MIS must have the capabilities to:

1. Calculate payment amounts according to the fee schedules, per diems, rates, formulas, and rules established by the Contractor.
2. Maintain access to pricing and reimbursement methodologies to appropriately price claims at the Contractor's allowable amount.
3. Maintain flexibility to accommodate future changes and expanded implementation of co pays.
4. Deduct Member liability amounts from payment amounts as defined by the Department.
5. Deduct TPL amounts from payments amounts.
6. Provide adjustment processing capabilities.
- 7.

## **VI. Claims Operations Management**

The Claims Operations Management function provides the overall support and reporting for all of the Claims processing functions.

### **A. Inputs**

The inputs to the Claims Operations Management function must include all the claim records from each processing cycle and other inputs described for the Claims Control and Entry function.

### **B. Processing Requirements**

The primary processes of Claims Operations Management are to maintain sufficient on-line claims information, provide on-line access to this information; and produce claims processing reports. The claims operations management function of the MIS must:

1. Maintain Claim history at the level of service line detail.
2. Maintain all adjudicated (paid and denied) claims history. Claims history must include at a minimum:
  - All submitted diagnosis codes (including service line detail, if applicable);
  - Line item procedure codes, including modifiers;
  - Member ID and medical coverage group identifier;
  - Billing, performing, referring, and attending provider Ids and corresponding provider types;
  - All error codes associated with service line detail, if applicable;
  - Billed, allowed, and paid amounts;
  - TPL and Member liability amounts, if any;
  - Prior Authorization number;
  - Procedure, drug, or other service codes;
  - Place of service;
  - Date of service, date of entry, date of adjudication, date of

- payment, date of adjustment, if applicable.
3. Maintain non-claim-specific financial transactions as a logical component of Claims history.
  4. Provide access to the adjudicated and Claims in process, showing service line detail and the edit/audits applied to the Claim.
  5. Maintain accurate inventory control status on all Claims.

C. Reports

The following reports must be available from the Claims processing function ten days after the end of each month:

1. Number of Claims received, paid, denied, and suspended for the previous month by provider type with a reason for the denied or suspended claim.
2. Number and type of services that are prior-authorized (PA) for the previous month (approved and denied).
3. Amount paid to providers for the previous month by provider type.
4. Number of Claims by provider type for the previous month, which exceed processing timelines standards defined by the Department. Claim Prompt Pay reports as defined by ARRA

Additional detail regarding reports found in MCO Reporting Requirements.