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Attachment G

Medicaid Managed Care Contract

July 1, 2019-June 30, 2020Signature Page and Actual Contract

This contract is subject to the terms and conditions stated herein. By affixing signatures below, the parties verify that they are authorized to enter into this contract and that they accept and consent to be bound by the terms and conditions stated herein. In addition, the parties agree that (i) electronic approvals may serve as electronic signatures, and (ii) this contract may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all counterparts together shall constitute a single contract.

CHFS Cabinet Approval:

DocuSigned by:
Astrud Masterson
9E32A4DA9718411...

Signature

Deputy Executive Director

Title

Astrud Masterson

Printed Name

6/18/2019 | 9:47 AM EDT

Date

Contractor Approval:

David Delaney

Signature

Chief Financial Officer

Title

David Delaney

Printed Name

June 13, 2019

Date

CHFS Department Commissioner Review:

DocuSigned by:
Stephanie Bates
B7BCCE51E3BA494...

Signature

Deputy Commissioner

Title

Stephanie Bates

Printed Name

6/18/2019 | 7:58 AM PDT

Date

Approved as to form and legality:

DocuSigned by:
Catherine York
8B0AE383D31E403...

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MEDICAID MANAGED CARE CONTRACT

BETWEEN

THE COMMONWEALTH OF KENTUCKY
ON BEHALF OF
DEPARTMENT FOR MEDICAID SERVICES

AND

CONTRACTOR

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Preamble

This Contract is entered into among the Commonwealth of Kentucky, Finance and Administration Cabinet ("FAC"), and _____ ("Contractor").

WHEREAS, the Kentucky Department for Medicaid Services (DMS) ("Department") within the Cabinet for Health and Family Services is charged with the administration of the Kentucky Plan for Medical Assistance in accordance with the requirements of Title XIX of the Social Security Act of 1935, as amended (the "Act"), and the statutes, laws, and regulations of Kentucky; and the Kentucky Children's Health Insurance Program (KCHIP) in accordance with the requirements of the Title XXI of the Social Security Act, as amended, and

WHEREAS, the Contractor is eligible to enter into a risk contract in accordance with Section 1903(m) of the Act and 42 C.F.R. 438.6, is engaged in the business of providing prepaid comprehensive health care services as defined in 42 C.F.R. 438.2, and **Contractor** is an insurer under Subtitle 3 of the Kentucky Insurance Code with a health line of authority; and

WHEREAS, the parties are entering into this agreement regarding services for the benefit of Enrollees residing in the Commonwealth and, the Contractor has represented that the Contractor will exercise appropriate financial responsibility during the term of this Contract, including adequate protection against the risk of insolvency, and that the Contractor can and shall provide quality services efficiently, effectively and economically during the term of this Contract, and further the Contractor shall monitor the quality and provision of those services during the term of this Contract, representations upon which FAC and the Department rely in entering into this Contract;

NOW THEREFORE, in consideration of the monthly payment of predetermined Capitated Rates by the Department, the assumption of risk by the Contractor, and the mutual promises and benefits contained herein, the parties hereby agree as follows:

1.0 Definitions

Abuse means Provider Abuse and Enrollee Abuse, as defined in KRS 205.8451.

ACA Expansion Enrollees means individuals less than 65 years of age with income below 138% of the federal poverty level and former foster children up to the age of twenty-six (26) and who were not previously eligible under Title XIX of the Social Security Act prior to the passage of the Affordable Care Act.

Adverse Benefit Determination means, as defined in 42 C.F.R. 438.400(b), the

A. denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit;
B. reduction, suspension, or termination of a service previously authorized by the Department, its agent or Contractor;
C. denial, in whole or in part, of payment for a service;
D. failure to provide services in a timely manner, as defined by Department;
E. failure of an MCO or Prepaid Health Insurance Plan (PHIP) to act within the timeframes required by 42 C.F.R. 438.408(b);

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F. for a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 C.F.R. 438.52(b)(2)(ii), to obtain services outside a Contractor's Network; or

G. denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Affiliate means an entity that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the entity specified.

Affordable Care Act means the Patient Protection and Affordable Act (PPACA), P.L. 111-148, enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010.

Allowed Medical Expenses equals incurred medical claims plus expenses for activities that improve health care quality (as defined in 45 C.F.R. 158.150).

Appeal means a request for review of an Adverse Benefit Determination, or a decision by the Contractor related to Covered Services, services provided or the payment for a service.

Behavioral Health Services means clinical, rehabilitative, and support services in inpatient and outpatient settings to treat a mental illness, emotional disability, or substance abuse disorder.

Behavioral Health Services Organization means an entity that is licensed as a behavioral health services organization pursuant to 902 KAR 20:430.

Business Associate means parties authorized to exchange electronic data interchange (EDI) transactions on the Trading Partner's behalf, as defined by HIPAA.

Cabinet means the Cabinet for Health and Family Services.

Capitation Payment means the total per Enrollee per month amount paid by the Commonwealth to the Contractor, for providing Covered Services to Enrollees enrolled.

Capitation Rate(s) means the amount(s) to be paid monthly to the Contractor by the Commonwealth for Enrollees enrolled based on such factors as the Enrollee's aid category, age, gender and service.

Care Coordination means the integration of all processes in response to an enrollee's needs and strengths to ensure the achievement of desired outcomes and the effectiveness of services.

Care Management System includes a comprehensive assessment and care plan care coordination and case management services. This includes a set of processes that arrange, deliver, monitor and evaluate care, treatment and medical and social services to an enrollee.

Care Plan means written documentation of decisions made in advance of care provided, based on a Comprehensive Assessment of an enrollee's needs, preference and abilities, regarding how services will be provided. This includes establishing objectives with the Enrollee and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing activity as long as care is provided.

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human

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service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.

C.F.R. means the Code of Federal Regulations.

Children with Special Health Care Needs means Enrollees who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.

CHIPRA means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that a State is able to continue its existing program and expands insurance coverage to additional low-income, uninsured children.

Claim means any 1) bill for services, 2) line item of service, or 3) all services for an enrollee within a bill.

CLIA means the federal legislation commonly known as the Clinical Laboratories Improvement Amendments of 1988 as found at Section 353 of the federal Public Health Services Act (42 U.S.C. §§ 201, 263a) and regulations promulgated hereunder.

Close of Business means 5:00 p.m. Eastern Time Zone.

CMS means the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid, formerly the Health Care Financing Administration.

Commonwealth means the Commonwealth of Kentucky.

Commission for Children with Special Health Care Needs (CCSHC) is a Title V agency which provides specialty medical services for children with specific diagnoses and health care services needs that make them eligible to participate in Commission sponsored programs, including provision of Medical care.

Comprehensive Assessment means the detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.

Community Mental Health Center (CMHC) is a board or a nonprofit organization providing a regional community health program operated pursuant to KRS Chapter 210 for individuals who have mental health disorders, substance abuse disorders, intellectual and/or developmental disabilities and may provide primary care.

Contract means this Contract between FAC and the Contractor and any amendments, including, corrections or modifications thereto incorporating and making a part hereof the documents described in Section 41.1 "**Documents Constituting Contract"** of this Contract.

Contractor's Network means collectively, all of the Providers that have contracts with the Contractor or any of the Contractor's subcontractors to provide Covered Services to Enrollees.

Contract Term means the term of this Contract as set forth in Section 7.1 "**Term**."

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Covered Services means services that the Contractor is required to provide under this Contract, as identified in this Contract.

Critical Access Hospitals means a health care facility designation of the federal Centers for Medicare and Medicaid Services (CMS) that provides for cost-based reimbursement for inpatient services.

Day means a calendar day unless otherwise noted. "Working day" or "business day" means Monday through Friday except for state holidays.

Decertification means any time the certification of any level of care in a hospital or residential facility is no longer authorized.

Denial means the termination, suspension or reduction in the amount, scope or duration of a Covered Service or the refusal or failure to provide a Covered Service, or the refusal or failure to pay for a service already rendered.

Department means the Department for Medicaid Services (DMS) within the Cabinet, or its designee.

Department for Aging and Independent Living (DAIL) is the Department within the Cabinet which oversees the administration of statewide programs and services on behalf of Kentucky's elders and individuals with disabilities.

Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) is the Department within the Cabinet that oversees the administration of statewide programs and services for individuals with mental health disorders, substance abuse disorders, intellectual disabilities, or developmental disabilities.

Department for Community Based Services (DCBS) is the Department within the Cabinet that oversees the eligibility determinations for the DMS and the management of the foster care program. DCBS has offices in every county of the Commonwealth.

Department of Insurance (DOI) is the Department within the Public Protection Cabinet which regulates the Commonwealth's insurance market, licenses agents and other insurance professionals, monitors the financial condition of companies, educates consumers to make wise choices, and ensures that Kentuckians are treated fairly in the marketplace.

Department for Medicaid Services (DMS) means the single state agency that submits to the Centers for Medicare and Medicaid Services (CMS) the state plan for the medical assistance program, and administers the program in accordance with the provisions of the state plan, the requirements of Title XIX of the Social Security Act, and all applicable Federal and state laws and regulations.

Disenrollment means an action taken by the Department to remove an enrollee's name from the HIPAA 834 following the Department's receipt and approval of a request for Disenrollment or a determination that the Enrollee is no longer eligible for Enrollment.

Drug Formulary/Preferred Drug List (PDL) means a list of prescriptions drugs, both generic and brand name, used to identify drugs with status (preferred or non-preferred) that offer the greatest overall value based on efficacy, safety and cost-effectiveness. The Preferred Drug List shall be maintained by a group of clinicians.

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Dual Eligible Enrollee means an enrollee who is simultaneously eligible for Medicaid and Medicare benefits.

Emergency Medical Condition is defined in 42 USC 1395dd (e) and 42 C.F.R. 438.114 and means:

A. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in
   1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
   2. Serious impairment of bodily functions, or
   3. Serious dysfunction of any bodily organ or part; or
B. With respect to a pregnant woman having contractions:
   1. That there is an inadequate time to effect a safe transfer to another hospital before delivery, or
   2. That transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services or Emergency Care means covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition.

Emergency Behavioral Health Disorder Services or Care means an emergent situation in which the Enrollee is in need of assessment and treatment in a safe and therapeutic setting, is a danger to himself or others, exhibits acute onset of psychosis, exhibits severe thought disorganization, or exhibits significant clinical deterioration in a chronic behavioral condition rendering the Enrollee unmanageable and unable to cooperate in treatment.

Encounter means a service or item provided to a patient through the healthcare system that includes but are not limited to:

A. Office visits;
B. Surgical procedure;
C. Radiology, including professional and/or technical components;
D. Prescribed drugs including mental/behavioral drugs;
E. DME;
F. Transportation;
G. Institutional stays;
H. EPSDT screening; or
I. A service or item not directly provided by the Plan, but for which the Plan is financially responsible. An example would include an emergency service provided by an out-of-network provider or facility.

Encounter File means an electronically formatted record of multiple Encounters using data elements as established by the Department.

Encounter Technical Workgroup means a workgroup composed of representatives from Contractor, the Department, the Fiscal Agent, and EQRO.

Encounter Void means an accepted or Erred Encounter Record that has been removed from all Encounter Records.

Enrollee means an individual as defined in 42 C.F.R. 438.10(a).

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Enrollee Listing Report means the HIPAA 834 transaction file which indicates Contractor's Enrollees and any new, terminated and changed Enrollees and the HIPAA 820 transaction file which indicates the Capitation Payment for Contractor's Enrollees, as reconciled against one another.

Enrollment means an action taken by the Department to add an Enrollee's name to the HIPAA 834 following approval by the Department of an eligible Enrollee to be enrolled.

EPSDT means Early and Periodic Screening, Diagnosis and Treatment Program.

EPSDT Special Services means any necessary health care, diagnostic services, treatment, and other measure described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses, and conditions identified by EPSDT screening services, whether or not such services are covered under the State Medicaid Plan.

EQRO means the external quality review organization, and its affiliates, with which the Commonwealth may contract as established under 42 C.F.R. 438, Subpart E.

Erred Encounter means an Encounter that has failed to satisfy one or more requirements for valid submission.

Erred Encounter File means an Encounter File that is rejected by the Department because it has failed to satisfy the requirements for submission.

Execution Date means the date upon which this Contract is executed by FAC, the Department, and the Contractor.

Family Planning Services means counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy.

Fiscal Agent means the agent contracted by the Department to audit Provider Claims: process and audit Encounter data; and, to provide the Contractor with eligibility, provider, and processing files.

Fraud means any act that constitutes fraud under applicable federal law or KRS 205.8451-KRS 205.8483.

Federally Qualified Health Center (FQHC) means a facility that meets the requirements of Social Security Act at 1905(l)(2).

Foster Care means the DCBS program which provides temporary care for children placed in the custody of the Commonwealth who are waiting for permanent homes.

FTE means full-time equivalent for an employee, based on forty (40) hours worked per week.

Grievance means the definition established in 42 C.F.R. 438.400.

Grievance and Appeal System means a comprehensive system that includes a grievance process, an appeal process, and access to the Commonwealth's fair hearing system.

Health Care Effectiveness Data and Information Set (HEDIS™) means a national tool used to measure performance on important dimensions of care of services.

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Health Information means any health information provided and/or made available by the Department to a Trading Partner, and has the same meaning as the term "health information" as defined by 45 C.F.R. Part 160.103.

HHS means the United States Department for Health and Human Services.

HHS Transaction Standard Regulation means 45 C.F.R., at Title 45, Parts 160 and 162, as may be amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, and the implementing regulations (45 C.F. R. Sections 142, 160, 162, and 164), all as may be amended.

HIPAA 820 means a transaction file prepared by the Department that indicates Enrollee's capitated payment.

HIPAA 834 means a transaction file prepared by the Department that indicates all Enrollees enrolled.

HMO means a Health Maintenance Organization licensed in the Commonwealth pursuant to KRS 304.38, et seq.

Homeless Person, when used in the context of Section 23.4-Outreach to Homeless Persons, means one who lacks a fixed, regular or nighttime residence; is at risk of becoming homeless in a rural or urban area because the residence is not safe, decent, sanitary or secure; has a primary nighttime residence at a publicly or privately operated shelter designed to provide temporary living accommodations; has a primary nighttime residence at a public or private place not designed as regular sleeping accommodations; or is a person who does not have access to normal accommodations due to violence or the threat of violence from a cohabitant.

Health Risk Assessment (HRA) means a screening tool used to collect information on an Enrollee's health status that includes, but is not limited to Enrollee demographics, personal and family medical history, and lifestyle. The assessment will be used to determine Enrollee's needs for care management, disease management, behavioral health services and/or other health or community services.

Individuals with Disabilities Education Act (IDEA) is a law ensuring services to children with disabilities. IDEA governs how states and public agencies provide early intervention, special education and related services to eligible infants, toddlers, children and youth with disabilities.

Individual Education Plan (IEP) means medically necessary services for an eligible child coordinated between the schools and the Contractor that complement school services and promote the highest level of function for the child.

Individuals with Special Healthcare Needs (ISHCN) are Enrollees who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISHCN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these Enrollees so the MCO can facilitate access to appropriate services.

Insolvency means the inability of the Contractor to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities. "Liabilities," for purposes of the definition of

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Insolvency, shall include, but not be limited to, claims payable required by the Kentucky Department of Insurance pursuant to Kentucky statutes, laws or regulations.

Institution for Mental Disease (IMD) is defined by 42 C.F.R. 435.1010.

Insurer is an insurer under Subtitle 3 of the Kentucky Insurance Code with a health line of authority.

I/T/U means ("I") Indian Health Service, ("T") Tribally operated facility/program, and ("U") Urban Indian clinic.

Kentucky HEALTH refers to the Section 1115 Demonstration Waiver known as Kentucky Helping to Engage and Achieve Long Term Health (HEALTH).

Kentucky HEALTH Business Requirements refer to the technical and operational guidelines and documents, provided to the contractor by the Department, which outline how the various Kentucky HEALTH information systems, including the Contractor's, are required to operate and interface with each other. This includes, but is not limited to, the Kentucky HEALTH High Level Requirements document, Detailed Design documents, Invoicing and Payment Reporting Guides, Special Terms and Conditions (STCs), and Companion Guides.

Kentucky Health Information Exchange (KHIE) means the secure electronic information infrastructure created by the Commonwealth for sharing health information among health care providers and organizations and offers health care providers the functionality to support meaningful use and a high level of patient-centered care.

Legal Entity means any form of corporation, insurance company, Limited Liability Company, partnership, or other business entity recognized as being able to enter into contracts and bear risk under the laws of both the Commonwealth and the United States.

Managed Care Organization (MCO) means an entity for which the Commonwealth has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

Marketing means any communication from or on behalf of the Contractor, that can reasonably be interpreted as intended to influence the beneficiary to enroll with the MCO, or either to not enroll in or to disenroll from another MCO as defined by 42 C.F.R. 438.104.

Maximum Allowable Cost (MAC) means the upper limits that a plan will pay for generic drugs and brand name drugs that have generic version available (multi-source brands).

Medicaid Region means one of eight multi-county Regions within Kentucky. A list of counties comprising each Region is attached as Appendix "A".

Medical Loss Ratio (MLR) equals Allowed Medical Expenses divided by Net Capitation Payments.

Medical Record means a single complete record that documents all of the treatment plans developed for, and medical services received by, the Enrollee including inpatient, outpatient, referral services and Emergency Care whether provided by Contractor's Network or Out of Network Providers.

Medically Necessary or Medical Necessity means Covered Services which are medically necessary as defined under 907 KAR 3:130, meet national standards, if applicable, and provided

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in accordance with 42 C.F.R. § 440.230, including children's services pursuant to 42 U.S.C. 1396d(r).

Miles, unless otherwise noted, means the distance traveled using public roadways.

MIS means Management Information System.

Modified Adjusted Gross Income (MAGI) means the calculation under the ACA used to determine income eligibility for Medicaid based upon federal income tax rules which include family size and household income based on the tax filing unit.

National Correct Coding Initiative (NCCI) means CMS developed coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits.

Net Capitation Payment equals earned premiums minus federal, state and local taxes and licensing or regulatory fees.

Network Provider means any provider, group of providers, or entity that has a network provider agreement with the Contractor or the Contractor's subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services.

Non-covered Services means health care services that the Contractor is not required to provide under the terms of this Contract.

NPI means the national provider identifier, required under HIPAA.

Office of Inspector General (OIG) is Kentucky's regulatory agency for licensing all health care agencies in the Commonwealth. The OIG is responsible for the prevention, detection and investigation of Medicaid fraud, abuse, waste, and mismanagement.

Office of Attorney General (OAG) The Attorney General is the chief law officer of the Commonwealth of Kentucky and all of its departments, commissions, agencies, and political subdivisions, and the legal adviser of all state officers, departments, commissions, and agencies.

Out-of-Network Provider means any person or entity that has not entered into a participating provider agreement with Contractor or any of the Contractor's subcontractors for the provision of Covered Services.

Overpayment means any payment made to a provider by the Contractor to which the provider is not entitled.

Person-Centered Recovery Planning (PCRP) means a collaborative process resulting in a recovery oriented behavioral health treatment plan needed for maximum reduction of mental disability and restoration of a recipient to his/her best possible functional level.

Point-of-Sale (POS) means state-of-the-art, online and real-time rules-based Claims processing services with prospective drug utilization review including an accounts receivable process.

Post Stabilization Services means Covered Services, related to an Emergency Medical Condition, that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R. 438.114(e) to improve or resolve the Enrollee's condition.

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Prepayment review means a specific review of identified claims or services or types of claims or services prior to determination and payment in order to prevent improper payments due to a sustained or high level of payment error or resulting from an analysis that identifies a problem related to possible Fraud, Waste, and/or Abuse.

Presumptive eligibility means eligibility granted for Medicaid-covered services as specified in administrative regulation as a qualified individual based on an income screening performed by a qualified provider.

Prevalent non-English language means any non-English language spoken by five (5) percent or more of the population in Kentucky and any non-English language spoken by five (5) percent of more of the population in a county served by the Contractor.

Primary Care Provider (PCP) means a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse, physician assistant, or health clinic, including an FQHC, FQHC look-alike, primary care center, or RHC that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to individuals, and for an Enrollee who has a gynecological or obstetrical health care needs, disability or chronic illness, is a specialist who agrees to provide and arrange for all appropriate primary and preventive care.

Prior Authorization means Contractor's act of authorizing specific services before they are rendered.

Program Integrity means the process of identifying and referring any suspected Fraud or Abuse activities or program vulnerabilities concerning the health care services to the Cabinet's Office of the Inspector General.

Prospective Drug Utilization Review (ProDUR) means a monitoring system that screens prescription drug claims to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, drug allergy, and clinical misuse or abuse, as required by 42 C.F.R. 438.3(s) and complies with 1927(g) and 42 C.F.R. part 456, subpart K.

Protected Health Information (PHI) means individual patient demographic information, Claims data, insurance information, diagnosis information, and any other care or payment for health care that identifies the individual (or there is reasonable reason to believe could identify the individual), as defined by HIPAA.

Provider means any person or entity under contract with the Contractor or its contractual agent that provides Covered Services to Enrollees.

Psychiatric Residential Treatment Facilities (PRTF) means a non-hospital facility that has a provider agreement with the Department to provide inpatient services to Medicaid-eligible individuals under the age of 21 who require treatment on a continuous basis as a result of a severe mental or psychiatric illness. The facility must be accredited by JCAHO or other accrediting organization with comparable standards recognized by the Commonwealth. PRTFs must also meet the requirements in §441.151 through 441.184 of the C.F.R.

QAPI means quality assessment and performance improvement program, as required by 42 C.F.R. 438.330.

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Quality Improvement (QI) means the process of assuring that Covered Services provided to Enrollees are appropriate, timely, accessible, available, and Medically Necessary and the level of performance of key processes and outcomes of the healthcare delivery system are improved through the Contractor's policies and procedures.

Quality Management means the integrative process that links knowledge, structure and processes together throughout the Contractor's organization to assess and improve quality.

Rate Area means one of two geographic areas composed of Medicaid Regions for which rate cells are developed. Rate Area A is comprised of Medicaid Region 3. Rate Area B is comprised of Medicaid Regions 1, 2, 4, 5, 6, 7, and 8.

Rate Cell means **c**overed eligibility categories segmented into sub-groups based on an analysis of similarities of the per capita costs, age, and gender of various populations.

Rate Group means rate cell level information aggregated into eight larger but similarly characterized groups including 1) Families and Children – Child, 2) Families and Children – Adult, 3) SSI without Medicare Adult, 4) SSI Child and 5) Foster Care Child, 6) Dual Eligibles, 7) ACA MAGI Adults, and 8) ACA Former Foster Care Child.

Retrospective Drug Utilization Review (RetroDUR) means a process that involves ongoing and periodic examination of pharmacy claims data to identify patterns of fraud, abuse, gross overuse, or medically unnecessary care and implements corrective action when needed, as required by 42 C.F.R. 438.3(s) and complies with 1927(g) and 42 C.F.R. part 456, subpart K.

Rural Health Clinic (RHC) means an entity that meets all of the requirements for designation as a rural health clinic under 1861(aa)(1) of the Social Security Act and approved for participation in the Kentucky Medicaid Program.

Service Location means any location at which an Enrollee may obtain any Covered Services from the Contractor's Network Provider.

Serious Emotional Disorder (SED) means a child with a clinically significant disorder as described in KRS 200.503.

Severe Mental Illness (SMI) means a major mental illness or disorder (but not a primary diagnosis of Alzheimer's disease or dementia) as included in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM), under: schizophrenia spectrum and other psychotic disorders; bipolar and related disorders; depressive disorders; or post-traumatic stress disorders and has documented history indicating persistent disability and significant impairment in major areas of community living; and has clinically significant symptoms for at least two years or has been hospitalized for mental illness more than once within the two past years; and has significant impairment that impedes functioning in two or more major areas of living and is unlikely to improve without treatment, services and/or supports.

Service Authorization Request means an Enrollee's request for the provision of a service.

Specialty Care means any service provided that is not provided by a PCP.

State means the Commonwealth of Kentucky.

State Fair Hearing means the administrative hearing provided by the Cabinet pursuant to KRS Chapter 13B and contained in 907 KAR 17.010.

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Supplemental Security Income (SSI) is a program administered by the Social Security Administration (SSA) that pays benefits to disabled adults and children who have limited income and resources. SSI benefits are also payable to people 65 and older without disability who meet the financial limits.

Subcontract means any agreement entered into, directly or indirectly, by a Contractor to provide or arrange for the provision of Covered Services. The term "Subcontract" does not include a policy of insurance or reinsurance purchased by a Contractor or a Subcontractor to limit its specific or aggregate loss with respect to Covered Services provided to Enrollees hereunder provided the Contractor or its risk-assuming Subcontractor assumes some portion of the underwriting risk for providing health care services to Enrollees.

Subcontractor means any individual or entity other than a Provider, Physician Health Organization, or Network Provider, with which Contractor has entered into a written agreement for the purpose of fulfilling a Contractor's obligations under an MCO Contract.

Symmetrical Risk Corridor means the same size corridors of risk sharing percentages above and below a target amount designed to limit exposure to unexpected expenses.

Teaching hospital means a hospital providing the services of interns or residents-in-training under a teaching program approved by the appropriate approving body of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. In the case of interns or residents-in-training in the field of dentistry in a general or osteopathic hospital, the teaching program shall have the approval of the Council on Dental Education of the American Dental Association. In the case of interns or resident-in-training in the field of podiatry in a general or osteopathic hospital, the teaching program shall have the approval of the Council on Podiatry Education of the American Podiatry Association.

Third-Party Liability/Resource means any resource available to an Enrollee for the payment of expenses associated with the provision of Covered Services, including but not limited to, Medicare, other health insurance coverage or amounts recovered as a result of settlement, dispute resolution, award or litigation. Third Party Resources do not include amounts that are exempt under Title XIX of the Social Security Act.

Trading Partner means a provider or a health plan that transmits health information in electronic form in connection with a transaction covered by 45 C.F.R. Parts 160 and 162, or a business associate authorized to submit health information on the Trading Partner's behalf, as defined by HIPAA.

Transaction means the exchange of information between two (2) parties to carry out financial or administrative activities related to health care as defined by 45 C.F.R. Part 160.103, as defined by HIPAA.

Urgent Care means care for a condition not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment.

Waste means generally, but is not limited to, the overutilization or inappropriate utilization of services or misuse of resources, and typically is not a criminal or intentional act.

Women, Infants and Children (WIC) means a federally-funded health and nutrition program for women, infants, and children.

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Kentucky HEALTH Definitions

Alternative Benefit Plan (ABP) means the benefit package provided to ACA Expansion Enrollees which is developed by the Department in accordance with 42 CFR Part 440, Subpart C.

Ad Hoc Invoice means invoicing done outside of the Batch Invoicing of actively eligible and enrolled Kentucky HEALTH Enrollees on the fifteenth day of each month. Ad Hoc Invoicing shall be completed within three (3) business days of the Contractor's receipt of the applicable HIPAA 834 record.

Batch Invoicing or Batch Invoice means invoicing of actively eligible and enrolled Kentucky HEALTH Enrollees on the fifteenth day of each month for the next coverage month.

Benefit Year means the time period of January 1 through December 31 of each calendar year.

Provider Attestation refers to the Department's designated form for completion by Medicaid Providers to document the clinical assessment of an Enrollee's Medically Frail status.

Provider Attestation Scoring Tool refers to the Department defined processes to score the results of a Provider Attestation for purposes of determining an Enrollee's Medically Frail status.

Community Engagement (CE) refers to the Kentucky HEALTH initiative whereby non-exempt Enrollees shall complete at least eighty (80) hours per month of qualifying activities to maintain eligibility. Community Engagement qualifying activities are defined separately. This initiative shall be marketed as the Partnering to Advance Training and Health (PATH) program.

Community Engagement Qualifying Activities refer to activities deemed to meet the Community Engagement requirement of eighty (80) hours per month. Such activities include volunteering, caregiving, education, job training, employment, or participation substance use disorder treatment activities.

Community Engagement Suspension means the penalty applied to Kentucky HEALTH Enrollees who do not complete their required Community Engagement hours. Enrollees in a Community Engagement Suspension remain enrolled in Kentucky HEALTH, but not eligible for benefits during the suspension period.

Conditionally Eligible Enrollee means an applicant who has been determined to meet all Kentucky HEALTH eligibility criteria, but who has not made an initial premium payment or otherwise cleared a penalty in order to start coverage. Conditionally Eligible Enrollees are not eligible to receive Kentucky HEALTH benefits.

Copayment Plan is the cost sharing plan for ACA Expansion Enrollees, Parent and Caretaker Relatives, and TMA Enrollees at or below one hundred percent (100%) FPL who fail to make required Kentucky HEALTH premium payments. Enrollees in the Copayment Plan do not have access to a My Rewards Account, and are charged copayments for covered services in accordance with the Kentucky Medicaid State Plan.

Cost Sharing Exempt refers to Kentucky HEALTH Enrollees who are excluded from the requirement or option to contribute toward the cost of their health coverage. It includes Pregnant Women and Kentucky HEALTH Children.

Cost Sharing Optional refers to Kentucky HEALTH Enrollees who are not required to contribute toward the cost of their health coverage as a condition of eligibility. It includes Former Foster

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Youth to age 26 and Medically Frail Individuals. These Enrollees can choose to make monthly Kentucky HEALTH premium payments in order to gain access to a My Rewards Account.

Cost Sharing Required includes ACA Expansion Enrollees, Parent and Caretaker Relatives, and TMA Enrollees who are required to contribute to the cost of their coverage via monthly premium payments or copayments for every Kentucky HEALTH covered benefit received.

Debt means any unpaid premium amounts the Contractor may collect from an Enrollee. Payment of Debt is neither a condition of eligibility nor required to cure a Non-Payment Penalty.

Deductible Account is state-funded administrative tracking account in the amount of $1000.00 designed to expose Kentucky HEALTH Enrollees to the cost of healthcare, designed to encourage them to be active consumers by evaluating cost and quality of care. It is funded with State dollars, not with Contractor or Enrollee dollars. The first one thousand dollars ($1,000.00) of non-preventive services received by Enrollees within a benefit year are tracked against the Deductible Account and documented on a monthly statement sent to Enrollees. Half of the remaining Deductible Account balance at the end of the benefit year (up to $500.00) is eligible to be rolled over into the My Rewards Account.

Deemed Newborns are children enrolled in Kentucky HEALTH who meet the requirements described in 42 CFR §435.117.

Fast Track Payment means a Department-determined advance premium dollar amount that applicants may opt to pay to expedite Kentucky HEALTH coverage to the first day of the month in which the payment is made, which may be as early as the first day of the month of application.

Former Foster Youth are Kentucky HEALTH Enrollees who are under age twenty-six (26) and were in foster care under the responsibility of the State or a Tribe within Kentucky or another State and enrolled in Medicaid on the date of attaining age eighteen (18) or such higher age as the State elected.

Head of Household refers to the individual who initiates Medicaid application on behalf of a MAGI household. The Head of Household is not always enrolled in Kentucky HEALTH or with the Contractor. Kentucky HEALTH premium invoices are sent to the Head of Household, identified by the Cabinet on the HIPAA 834, unless otherwise requested by the household.

Integrated Eligibility and Enrollment System (IEES) means the information technology system utilized by the Cabinet to integrate eligibility and enrollment determination functions for all State-administered health and human services programs.

KCHIP Enrollee means a child enrolled in the Kentucky Children's Health Insurance Program.

Kentucky HEALTH Children means Deemed Newborns as described at 42 CFR §435.117 and infants and children under age 19 as described at 42 CFR §435.118. It does not include KCHIP Enrollees.

Kentucky HEALTH Enrollee means an Enrollee who is enrolled in one of the following eligibility groups: (i) ACA Expansion Enrollee; (ii) Parent and Caretaker Relative; (iii) TMA; (iv) Pregnant Women; (v) Former Foster Youth; (vi) Kentucky HEALTH Children; and (vii) KCHIP.

Medically Frail means an ACA Expansion Enrollee, Parent and Caretaker Relative or TMA Enrollee who, in accordance with 42 CFR §440.315(f), and Department developed criteria, has a disabling mental disorder (including serious mental illness), chronic substance use disorder,

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serious and complex medical condition, or a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living. Enrollees who meet the definition of Medically Frail shall not be subject to (i) Community Engagement requirements; (ii) mandatory cost sharing through premiums or copayments; or (iii) enrollment in the ABP.

Medically Frail Identification Tools mean the Department-defined processes established to determine an individual's Medically Frail status in accordance with 42 CFR §440.315(f).

My Rewards Account is an account available to Kentucky HEALTH Enrollees, other than Kentucky HEALTH Children and KCHIP Enrollees. Enrollees, with the exception of Pregnant Women, shall make their required premium payment contribution to have an active My Rewards Account. Enrollees can accrue funds into their My Rewards Accounts by completing Department-approved activities such as completion of healthy activities or preventive services, Funds in the My Rewards Account can be utilized to purchase Department defined services not otherwise available through the Enrollee's covered benefit package.

Non-Payment Penalty refers to a 6-month penalty period applied to Cost-Sharing Required Enrollees who fail to make timely premium payments. Individuals at or below one hundred percent (100%) FPL and subject to a Non-Payment Penalty are enrolled in the Copayment Plan. Individuals above one hundred percent (100%) FPL and subject to a Non-Payment Penalty are suspended from eligibility for Kentucky HEALTH. A twenty-five dollar ($25) My Rewards Account deduction is also applied.

Parent and Caretaker Relative means a Kentucky HEALTH Enrollee who meets the requirements at 42 CFR §435.110.

Past Due means the total amount that an Enrollee is required to pay either to avoid a Non-Payment Penalty or to end a Non-Payment Penalty prior to the expiration of the six-month penalty period; it does not include Debt.

Possibly Medically Frail refers to the output of the Medically Frail Identification Tool which requires additional information through the Provider Attestation for determination of Medically Frail status.

Potentially Medically Frail refers to Kentucky HEALTH Enrollees who have been identified as requiring determination of Medically Frail status via the Medically Frail Identification Tool.

Pregnant Women are Kentucky HEALTH Enrollees who meet the requirements at 42 CFR §435.116.

Premium Plan is the cost sharing plan Kentucky HEALTH Enrollees are defaulted to at transition as of 7/1/2018, enrolled in upon initial application, and continuously enrolled in as long as they make their required monthly premium payments. Enrollees in the Premium Plan do not incur any other cost sharing for their healthcare coverage, and have access to a My Rewards Account.

Random Control Trial (RCT) means the evaluation of the Kentucky HEALTH program in which Enrollees otherwise eligible for Kentucky HEALTH are allocated at random to a control group through which the policies and procedures of Kentucky HEALTH are not applied.

Re-Entry Course is an educational course, identified by the Department, required for Kentucky HEALTH Enrollees in a suspension or penalty status to end the applicable suspension or penalty and gain early re-entry into Kentucky HEALTH coverage.

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Special Terms and Conditions (STC) refers to the agreement between CMS and the State regarding the requirements and assurances that govern the operation of Kentucky HEALTH.

Transitional Medical Assistance (TMA) means a Kentucky HEALTH Enrollee who meets the requirements of Section 1925 of the Social Security Act.

Voluntary Withdrawal Penalty is a six (6) month penalty period applied to Kentucky HEALTH Enrollees who disenroll from the program without cause. Individuals in this penalty period are not eligible to re-enroll in Kentucky HEALTH until the six (6) month period expires, unless early re-entry requirements are met.

2.0 Abbreviations and Acronyms

ABP – Alternative Benefit Plan

ADA - American Dental Association

AHRQ - Agency for Health Care Research and Quality

AIDS - Acquired Immune Deficiency Syndrome

APRN - Advanced Practice Registered Nurse

A/R - Accounts Receivable

BBA - Balanced Budget Act

BH - Behavioral Health

BIN - NCPDP Processor ID Number

CAHPS - Consumer Assessment of Health Care Providers and Systems

CAP - Corrective Action Plan

CCD - Continuity of Care Document

CE – Community Engagement

C.F.R. - Code of Federal Regulations

CHFS - Cabinet for Health and Family Services

CMHC - Community Mental Health Center

CMS - Centers for Medicare and Medicaid Services

CMS-416 - Centers for Medicare and Medicaid Services-416 (form)

CMS-1500 - Centers for Medicare and Medicaid Services-1500 (form)

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COB - Coordination of Benefits

COPD - Chronic Obstructive Pulmonary Disease

CPT - Current Procedural Terminology

DEA - Drug Enforcement Administration

DIVERTS - Direct Intervention: Vital Early Responsive Treatment Systems

DSH - Disproportionate Share Hospital

DSM-V - Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

EEO - Equal Employment Opportunity

EHR – Electronic Health Records

EQR - External Quality Review

EQRO - External Quality Review Organization

FAC - Finance and Administration Cabinet.

FFS - Fee-For-Service

FPL – Federal Poverty Level

FQHC - Federally Qualified Health Center

FTE - Full-time Equivalent

HCPCS - Health Care Common Procedure Coding System

HEDIS - Health Care Effectiveness Data and Information Set

HIPAA - Health Insurance Portability and Accountability Act

HIV - Human Immunodeficiency Virus

HRA - Health Risk Assessment

HTTP - Hyper Text Transport Protocol or Hyper Text Transfer Protocol

ICD-9-CM - International Classification of Diseases, Ninth Revision, Clinical Modification

ICD-10-CM - International Classification of Diseases, Tenth Revision, Clinical Modification

ICF-IID - Intermediate Care Facility for Individuals with Intellectual Disabilities

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ICN – Internal Control Number

KAR - Kentucky Administrative Regulation

KCHIP – Kentucky Children's Health Insurance Program

KRS - Kentucky Revised Statute

LPN - Licensed Practical Nurse

MAC – Maximum Allowable Cost

MAGI – Modified Adjusted Gross Income

MCO - Managed Care Organization

MBHO - Managed Behavioral Healthcare Organization

MMIS - Medicaid Management Information System

NCCI – National Correct Coding Initiative

NCPDP - National Council for Prescription Drug Programs

NCQA - National Committee for Quality Assurance

NDC - National Drug Code

NPI - National Provider Identifier

OBRA - Omnibus Budget Reconciliation Act

OSCAR – Online Survey Certification and Reporting

PA – Prior Authorization

PATH – Partnering to Advance Training and Health

PCN - Processor Control Number

PCP - Primary Care Provider

PCRP - Person-Centered Recovery Planning

PDL – Preferred Drug List

PMPM – Per Member Per Month

POS – Point of Sale

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ProDUR – Prospective Drug Utilization Review

PRTF - Psychiatric Residential Treatment Facility

P&T - Pharmacy and Therapeutics Committee

QAPI - Quality Assessment and Performance Improvement

R/A - Remittance Advice

RAC – Recovery Audit Contractor

RetroDUR – Retrospective Drug Utilization Review

RFP - Request for Proposal

RHC - Rural Health Clinic

RN - Registered Nurse

SOBRA - Sixth Omnibus Budget Reconciliation Act

SSI - Supplemental Security Income

STC – Special Terms and Conditions

TANF - Temporary Assistance for Needy Families

TMA – Transitional Medical Assistance

TTY-TTD – TeleTypewriter-Telecommunications Device for the Deaf

TPL - Third Party Liability

UB-92 - Universal Billing 1992 (form)

UB-04 - Universal Billing 2004 (form)

UCF – Universal Claim Form

UM - Utilization Management

URAC - Utilization Review Accreditation Commission

USC - United States Code

VPN - Virtual Private Network

WIC - Women, Infants and Children

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WS-Security - Web Services-Security

3.0 Contractor Terms

3.1 Contractor Representations and Warranties

The Contractor represents and warrants that the following are true, accurate and complete statements of fact as of the Execution Date and that the Contractor shall take all actions and fulfill all obligations required so that the representations and warranties made in this Contract shall remain true, accurate and complete statements of fact throughout the term of the Contract.

3.2 Organization and Valid Authorization

Contractor is a Legal Entity duly organized, validly existing and in good standing under the laws of the Commonwealth, and is in full compliance with all material Commonwealth requirements and all material municipal, Commonwealth and federal tax obligations related to its organization as a Legal Entity. The obligations and responsibilities set forth in this Contract have been duly authorized under the terms of the laws of the Commonwealth and the actions taken are consistent with the Articles of Incorporation and By-laws of Contractor.

This Contract has been duly authorized and validly executed by individuals who have the legal capacity and authorization to bind the Contractor as set forth in this Contract. Likewise, execution and delivery of all other documents relied upon by FAC and the Department in entering into this Contract have been duly authorized and validly executed by individuals who have the legal capacity and corporate authorization to represent the Contractor.

3.3 Licensure of the Contractor

Contractor has a valid license to operate as an HMO or insurer, issued by the DOI. There are no outstanding unresolved material Appeals or Grievances filed against Contractor with DOI. Contractor has timely filed all reports required by DOI and DOI has taken no adverse action against Contractor of which FAC has not been notified.

As an HMO or insurer under Subtitle 3 of the Kentucky Insurance Code with a health line of authority, and regardless of the non-applicability of any other provision of the Kentucky Insurance Code or any legal authority cited herein, pursuant to this Contract the Contractor agrees to be subject to a one percent (1%) annual assessment on capitation payments that follow the provisions of any broad based assessment within state law including but not limited to the Governor's Enacted Budget, KRS 304.17B-021 or KRS 142.316, subject to the approval of CMS. The one percent (1%) assessment is a component of the Capitation Rates as contained in **Appendix A "Capitation Payment Rates**." On or about March 1st of each year, the Department shall notify the Contractor in writing that the annual assessment is due and the Contractor shall have 30 calendar days to remit payment in full to the Department. In the event the assessment is increased, the increase shall be provided for in an amended Capitation Rate. If CMS fails to approve this component of the rates, or if the assessment is otherwise deemed non-collectable, the capitation payment rates shall be adjusted to remove that component from the Capitation Rate.

3.4 Fiscal Solvency

As of the Execution Date, Contractor's statutory surplus is at or above the Regulatory Action Level as defined in the risk-based capital regulations applicable to designated HMO or insurer's licenses in the Commonwealth. The Contractor is not aware of any impending changes to its financial structure that could adversely impact its compliance with these requirements or its ability

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to pay its debts as they come due generally. The Contractor has not filed for protection under any Commonwealth or federal bankruptcy laws. None of the Contractor's property, plant or equipment has been subject to foreclosure or repossession within the preceding ten-year period, and the Contractor has not had any debt called prior to expiration within the preceding ten-year period.

3.5 Licensure of Providers

Each of the Providers, including individuals and facilities, which will provide health care services in Contractor's Network is validly licensed or, where required, certified to provide those services in the Commonwealth, including certification under CLIA, if applicable. Each Provider in the Contractor's Network has a valid Drug Enforcement Agency ("DEA") registration number, if applicable. Each provider in the Contractor's Network shall have a valid NPI and taxonomy, if applicable.

3.6 Ownership or Controlling Interest/Fraud and Abuse

Neither the Contractor nor any individual who has a controlling interest or who has a direct or indirect ownership interest of five (5) percent or more of the Contractor, nor any officer, director, agent or managing employee (i.e., general manager, business manager, administrator, director or like individual who exercises operational or managerial control over the Contractor or who directly or indirectly conducts the day-to-day operation of the Contractor) is an entity or individual (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. §1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)-(3) of the Social Security Act (42 U.S.C. §1320a-7(b)(1)-(3)); or (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVIII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the BBA or under a Commonwealth health care program.

Contractor shall require by contract that neither any Provider of health care services in the Contractor's Network, nor any individual who has a direct or indirect ownership or controlling interest of 5% or more of the Provider, nor any officer, director, agent or managing employee (i.e., general manager, business manager, administrator, director or like individual who exercises operational or managerial control over the Provider or who directly or indirectly conducts the day-to-day operation of the Provider) is an entity or individual (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. §1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)-(3) of the Social Security Act (42 U.S.C. §1320a-7(b)(1)-(3)); or (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVIII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the BBA or under a Commonwealth health care program.

The Contractor shall certify its compliance with 42 C.F.R. 438.610(a), (b) and (c) and have processes and/or procedures in place to ensure ongoing compliance throughout the life of the Contract.

3.7 Compliance with Federal Law

A. The Contractor shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):
   1. Furnished by any individual or entity during any period when the individual or entity is

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excluded from participation under Title V, XVIII, or XX of the Social Security Act or Sections 1128, 1128A, 1156, or 1842(j)(2), [203] of the Social Security Act;

2. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or pursuant to Section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);
3. Furnished by an individual or entity to whom the Department has suspended payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the Department determines there is good cause not to suspend such payments;
4. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;
5. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan;
6. For home health care services provided by an agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

B. The Capitation Payment provided by this Contract shall not be paid to the Contractor if it could be excluded from participation in Medicare or Medicaid for any of the following reasons:
   1. The Contractor is controlled by a sanctioned individual;
   2. The Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in Section 1128(b)(8)(B) of the Social Security Act;
   3. The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:
      a. Any individual or entity excluded from participation in Federal health care programs.
      b. Any entity that would provide those services through an excluded individual or entity.

C. Prohibited Affiliations.
   1. The Contractor shall not:
      a. Knowingly have a director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs;
      b. Knowingly have a person with ownership of more than 5% of the MCE's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs; or
      c. (Knowingly have an employment, consulting, or other agreement with an individual or entity for the provision of MCE contract items or services who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs.
   2. The Contractor shall provide written disclosure to the Department of any director; officer; partner; subcontractor, network provider; individual or entity with an employment, consulting, or other agreement; or any affiliation with a person or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
   3. If the Department learns that the Contractor has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the Department shall notify CMS of the noncompliance; may continue this Contract unless CMS directs otherwise; shall not renew or extend this Contract unless

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CMS provides to the Department a written statement describing compelling reasons that exist for renewing or extending the agreement.

D. The Contractor shall report to the Department and, upon request, to the Secretary of HHS, the Inspector General of the HHS, and the U. S. Comptroller General a description of transactions between the Contractor and a party in interest (as defined in Section 1318(b) of such Social Security Act), including the following transactions: (i) Any sale or exchange, or leasing of any property between the Contractor and such a party; (ii) Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; (iii) Any lending of money or other extension of credit between the Contractor and such a party. The Contractor shall make any reports of transactions between the Contractor and parties in interest that are provided to the Department, or other agencies available to Enrollees upon reasonable request.

E. The Contractor shall disclose to the Department any persons or corporations with an ownership or control interest in the Contractor that has direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Contractor's equity; owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least 5% of the value of the Contractor's assets; is an officer or director of the Contractor organized as a corporation, or is a partner of the Contractor organized as a partnership.

The disclosure shall contain: the name and address (The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address; date of birth and Social Security Number (in the case of an individual); other tax identification number (in the case of a corporation); whether the control interest in the Contractor or the Contractor's subcontractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; the name of any other Medicaid provider or fiscal agent in which the person or corporation has an ownership or control interest and the name, address, date of birth, and Social Security Number of any managing employee of the Contractor.

3.8 Pending or Threatened Litigation

All material threatened or pending litigation against the Contractor or its Affiliates has been disclosed in writing to FAC prior to the Execution Date. For purposes of this Section, litigation is material if a final finding of liability against the Contractor or its Affiliate(s), would create a substantial likelihood that the Contractor's ability to perform its obligations under this Contract would be significantly impaired. Any new material litigation filed against the Contractor or its Affiliates after the Execution Date will be disclosed in writing to FAC within ten (10) business days of receipt by the Contractor of notice new pending litigation. For purposes of this Section the term "litigation" shall mean any formal judicial or administrative proceeding.

4.0 Contractor Functions

4.1 Performance Standards

The Contractor shall perform or cause to be performed all of the Covered Services and shall develop, produce and deliver to the Department all of the statements, reports, data, accounting, Claims and documentation described and required by the provisions of this Contract, and the Department shall make payments to the Contractor on a capitated basis as described in this Contract. The Contractor acknowledges that failure to comply with the provisions of this Contract may result in the Commonwealth taking action pursuant to Sections 40.0 through 40.13, "**Remedies for Violation, Breach, or Non-Performance of Contract"**. The Contractor shall meet the applicable terms and conditions imposed upon Medicaid managed care organizations

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as set forth in 42 United States Code Section 1396b(m), 42 C.F.R. 438 et seq., 907 KAR Title 17, other related managed care regulations and the 1915 Waiver, as applicable.

4.2 Administration and Management

The Contractor shall be responsible for the administration and management of all aspects of the performance of all of the covenants, conditions and obligations imposed upon the Contractor pursuant to this Contract. No delegation of responsibility, whether by Subcontract or otherwise, shall terminate or limit in any way the liability of the Contractor to the Department for the full performance of this Contract.

The Contractor shall, directly or indirectly, maintain the staff and staff functions as specified in Section 9.2 "**Administration/Staffing**." The Contractor shall submit to the Department within ten (10) days any changes to the Contractor's Executive Management positions or other mandatory positions required under this Contract, and whenever requested by the Department, a current organizational chart depicting all staff functions, including but not limited to mandatory staff functions, the number of employees serving each function, and a description of the qualifications of each individual with key management responsibility for any mandatory function specified in Section 9.2 "**Administration/Staffing**."

Contractor agrees that its administrative costs shall not exceed ten percent (10%) of the total Medicaid managed care contract cost. Administrative costs are those costs consistent with DOI annual financial filings that are included in the line for "GAO" which is generally referred to as General, Administrative, and Overhead expenses.

4.3 Delegations of Authority

The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor in compliance with 42 C.F.R. 438.230. In addition to the provision set forth in Section 6.0 – 6.5 "**Subcontracts**," Contractor agrees to the following provisions.

A. There shall be a written agreement that specifies:
   1. Delegated activities and reporting responsibilities of the Subcontractor;
   2. Subcontractor agrees to comply with all applicable Medicaid laws and regulations including applicable subregulatory guidance and contract provisions;
   3. The right of the state, CMS, HHS Inspector General, the Comptroller General or their designee to audit, evaluate and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, determination of amounts payable under the MCO's contract with the State, or for reasonable possibility of fraud or similar risk;
   4. Subcontractor will make its premises, physical facilities, equipment, books records, contracts, computer or other electronic systems relating to its Medicaid Enrollees available;
   5. The right to audit through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and
   6. Provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate.
B. Before any delegation, the Contractor shall evaluate the prospective Subcontractor's ability to perform the activities to be delegated.
C. The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to a formal review at least once a year.
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.

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E. If the Contractor delegates selection of providers to another entity, the Contractor retains the right to approve, suspend, or terminate any provider selected by that Subcontractor.
F. The Contractor shall assure that the Subcontractor is in compliance with all Medicaid laws and regulations including applicable subregulatory guidance and contract provisions.

4.4 Approval of Department

Unless otherwise specified, the Contractor is required to submit any provider or Enrollee materials, information, or documents to the Department and all such submissions will be reviewed by the Department within (i) thirty (30) days for standard submissions or (ii) five (5) business days for expedited submissions.

Written material submitted to the Department for review and approval shall be considered received for review beginning with the date that the Department acknowledges to the Contractor receipt of the submission. Such acknowledgment may be demonstrated by evidence of a return receipt if sent via U.S. Mail, a delivery receipt if sent via e-mail, or the signature of a Cabinet for Health and Family Services employee taking receipt of the submission in the case of hand-delivery, including overnight mail or courier delivery.

4.5 General health education materials do not require prior approval by the Department. However, the Contractor shall ensure such materials are in compliance with this Contract and state and federal regulations and laws. The Contractor shall be subject to penalties for materials found to be non-compliant as set forth in Appendix B "Remedies for Violation, Breach, or Non-Performance of Contract."No Third Party Rights

This Contract does not, nor is it intended to, create any rights, benefits or interest to any Enrollee, provider, PHO, provider network, subcontractor, delegated subcontractor, supplier, corporation, partnership or other organization of any kind.

5.0 Contractor Conformance with Applicable Law, Policies and Procedures

5.1 Department Policies and Procedures

The Contractor shall comply with the applicable policies and procedures of the Department, specifically including without limitation the policies and procedures for MCO services, and all policies and procedures applicable to each category of Covered Services as required by the terms of this Contract. In no instance may the limitations or exclusions imposed by the Contractor with respect to Covered Services be more stringent than those specified in the applicable Department's policies and procedures without the approval of the Department. The Department shall provide reasonable prior written notice to Contractor of any material changes to its policies and procedures, or any changes to its policies and procedures that materially alter the terms of this Contract.

5.2 Commonwealth and Federal Law

At all times during the term of this Contract and in the performance of every aspect of this Contract, the Contractor shall strictly adhere to all applicable federal and Commonwealth law (statutory and case law), regulations and standards, in effect when this Contract is signed or which may come into effect or which may be amended or repealed during the term of this Contract, except where waivers of said laws, regulations or standards are granted by applicable federal or Commonwealth authority. In addition to the other laws specifically identified herein, Contractor shall comply with the Davis-Bacon Act and the Clean Air Act and Federal Water

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Pollution Control Act. The Contractor agrees to comply with the terms of 45 C.F.R. 93 Appendix A, as applicable.

Any change mandated by the Affordable Care Act which pertains to Managed Care Organizations (MCO) and/or Medicaid Services shall be implemented by the Contractor without amendment to this Contract. One such requirement listed in Section 2501 of PPACA pertains to the States collecting drug rebates for drugs covered under a MCO. The Contractor shall create and transmit a file according to the Department specifications which will allow for the Department or its contractors to bill drug rebates to manufacturers. The Contractor shall fully cooperate with Department and Department's contractors to ensure file transmissions are complete, accurate and delivered by the Department's specified deadlines. In addition, the Contractor shall assist and provide detailed Claim information requested by the Department or Department contractors to support rebate dispute and resolution activities.

5.3 Nondiscrimination and Affirmative Action

A. During the performance of this Contract, the Contractor agrees as follows:
B. The Contractor shall not discriminate against any employee or applicant for employment because of race, religion, color, national origin, sex, sexual orientation, gender identity or age. The Contractor further shall comply with the provision of the Americans with Disabilities Act of 1990 (Public Law 101- 336), 42 USC 12101, and applicable federal regulations relating thereto prohibiting discrimination against otherwise qualified disabled individuals under any program or activity. The Contractor shall provide, upon request, needed reasonable accommodations. The Contractor will take affirmative action to ensure that applicants are employed and that employees are treated during employment without regard to their race, religion, color, national origin, sex, age or disability. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor shall post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause or its nondiscriminatory practices.
C. The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor; state that all qualified applicants will receive consideration for employment without regard to race, religion, color, national origin, sex, sexual orientation, gender identity, age or disability.
D. The Contractor shall send to each labor union or representative of workers with which they have a collective bargaining agreement or other contract understanding, a notice advising the said labor union or workers' representative of the Contractor's commitments under this Section, and shall post copies of the notice in conspicuous places available to employees and applicants for employment. The Contractor shall take such action with respect to any Subcontract or purchase order as FAC may direct as a means of enforcing such provisions, including sanctions for noncompliance.
E. The Contractor shall comply with all applicable provisions and furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, as amended, and by the rules, regulations and orders of the Secretary of Labor, or pursuant thereto, and will permit access to their books, records and accounts by the administering agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations and orders.
F. In the event of the Contractor's noncompliance with the nondiscrimination clauses of this Contract or with any of the said rules, regulations or orders, this Contract may be canceled, terminated or suspended in whole or in part and the Contractor may be declared ineligible for further government contracts or federally-assisted construction contracts in accordance with procedures authorized in Executive Order No. 11246 of September 24, 1965, as amended, and such other sanctions may be imposed and remedies invoked as provided in

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or as otherwise provided by law.

G. The Contractor shall include the provision of paragraphs (1) through (7) of Section 202 of Executive Order No. 11246 in every Subcontract or purchase order unless exempted by rules, regulations or orders of the Secretary of Labor, issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, as amended, so that such provisions will be binding upon each subcontractor or vendor. Monitoring of Subcontractor compliance with the provisions of this Contract on nondiscrimination shall be accomplished during regularly scheduled quality assurance audits. Any reports of alleged violations of the requirements of this Section received by the Contractor, together with any suggested resolution of the alleged violation proposed by the Contractor in response to the report, shall be reported to FAC within five (5) business days. Following consultation with the Contractor, FAC shall advise the Contractor of any further action it may deem appropriate in resolution of the violation. The Contractor will take such action with respect to any Subcontract or purchase order as the administering agency may direct as a means of enforcing such provisions including sanctions for noncompliance; provided, however, that in the event the Contractor becomes involved in, or is threatened with, litigation with a Subcontractor as a result of such direction by the agency, the Contractor may request the United States to enter or intervene into such litigation to protect the interests of the United States. Contractor shall comply with Title IX of the Education Amendments of 1972 (regarding education programs and activities), if applicable.

5.4 Employment Practices

The Contractor agrees to comply with each of the following requirements and to include in any Subcontracts that any Subcontractor, supplier, or any other person or entity who receives compensation pursuant to performance of this Contract, a requirement to also comply with the following laws:

A. Title VI of the Civil Rights Act of 1964 (Public Law 88-352);
B. Title IX of the Education Amendments of 1972 (regarding education, programs and activities);
C. The Age Discrimination Act of 1975;
D. The Rehabilitation Act of 1973;
E. Rules and regulations prescribed by the United States Department of Labor in accordance with 41 C.F.R. Parts 60-741; and
F. Regulations of the United States Department of Labor recited in 20 C.F.R. Part 741, and Section 504 of the Federal Rehabilitation Act of 1973 (Public Law 93-112).

5.5 Governance

Contractor shall have a governing body. The governing body shall ensure adoption and implementation of written policies governing the operation of the Contractor's plan. The administrator or executive officer that oversees the day-to-day conduct and operations of the Contractor shall be responsible to the governing body. The governing body shall meet at least quarterly, and shall keep a permanent record of all proceedings available to the Cabinet, FAC, and/or CMS upon request. The Contractor shall have written policies and procedures for governing body elections detailing, at a minimum, the following: how board members will be elected; the length of the term for board members; filling of vacancies; and notice to Enrollees.

5.6 Access to Premises

The State, CMS, HHS Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the MCO, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment

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where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

The Contractor shall provide computer access in the event an audit, inspection, investigation or other on-site visit is conducted. The Contractor shall provide log-in credentials in order to access Contractor's claims and customer service systems on a read-only basis. The Contractor shall provide access to a locked space and office security credentials for use during business hours. All access under this Section shall comply with HIPAA's minimum necessary standards and any other applicable Commonwealth or federal law.

In addition, upon reasonable notice, the Contractor shall allow duly authorized agents or representatives of the Commonwealth or federal government or the independent external quality review organization access to the Contractor's premises during normal business hours, and shall cause similar access or availability to the Contractor's Subcontractors' premises to inspect, audit, investigate, monitor or otherwise evaluate the performance of the Contractor and/or its Subcontractors. The Contractor and/or Subcontractors shall forthwith produce all records, documents, or other data requested as part of such review, investigation, or audit.

In the event right of access is requested under this Section, the Contractor or Subcontractor shall provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the Commonwealth, federal, or external quality review personnel conducting the audit, investigation, or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the Contractor's or Subcontractors' activities. The Contractor shall have twenty (20) business days to respond to any findings of an audit performed by FAC, the Department or their agent before the findings are finalized. The Contractor shall cooperate with FAC, the Department or their agent as necessary to resolve audit findings. All information obtained will be accorded confidential treatment as provided under applicable laws, rules and regulations.

5.7 Waivers, State Innovation Models or Other Federal Initiatives

The Contractor shall participate, upon the Department's request, in any federal waivers, grant initiatives or awards or other program changes that develop, plan, create or implement any model that includes but is not limited to integration of behavioral health and physical health, improve health care delivery, reform payment, require Enrollee engagement or improve population health outcomes.

6.0 Subcontracts

6.1 Subcontractor Indemnity

Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors for the provision of Covered Services, shall contain an agreement by the Subcontractor to indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Enrollee from any liability whatsoever arising in connection with this Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor.

Each such Subcontractor shall further covenant and agree that in the event of a breach of the Subcontract by the Contractor, termination of the Subcontract, or insolvency of the Contractor, each Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to the

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Contractor, and shall fulfill all of its obligations respecting the transfer of Enrollees to other Providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of this Contract and any Subcontract.

6.2 Requirements

The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Enrollees or other services that involve risk-sharing, medical management, or otherwise interact with an Enrollee, except the Contractor shall not enter into any Subcontract with Subcontractors outside the United States. Such Subcontractors must be eligible for participation in the Medicaid program, as applicable. Each such Subcontract and any amendment to such Subcontract shall be in writing, and in un-redacted form and content approved by the Department. Further, any change in terms of a subcontract, suspension, or termination of a subcontract shall be shared with the Department for review and approval. The Contractor shall submit for review to the Department a template of each type of such Subcontract referenced herein. The Department may approve, approve with modification, or reject the templates if they do not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a Subcontract, the Department may consider such factors as it deems appropriate to protect the Commonwealth and Enrollees, including but not limited to, the proposed Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract including the processing of claims. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontractors within ten (10) days following termination. All approvals required by this section are subject to Section 4.4 "**Approval of Department**."

The Department's subcontract review shall assure that all Subcontracts:

A. Identify the population covered by the Subcontract;
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;
C. Specify procedures and criteria for extension, renegotiation and termination;
D. Specify that Subcontractors use only Medicaid enrolled providers in accordance with this Contract;
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;
F. Provide for monitoring by the Contractor of the quality of services rendered to Enrollees, in accordance with the terms of this Contract;
G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Enrollees of Medically Necessary Covered Services;
H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;
I. Contain an explicit provision that the Commonwealth is the intended third-party beneficiary of the Subcontract and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law;
J. Specify that Subcontractor where applicable, agrees to timely submit Encounter Records in the format specified by the Department so that the Contractor can meet the specifications required by this Contract;
K. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including without limitation, the obligation to comply with all applicable federal and Commonwealth law and regulations, including but not limited to, KRS 205.8451-8483, all rules, policies and procedures of FAC and the

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Department, and all standards governing the provision of Covered Services and information to Enrollees, all QAPI requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of FAC, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations, all indemnification and insurance requirements, and all obligations upon termination;

L. Provide for Contractor to monitor the Subcontractor's performance on an ongoing basis, including those with accreditation: the frequency and method of reporting to the Contractor; the process by which the Contractor evaluates the Subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;
M. A Subcontractor with NCQA/URAC or other national accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report;
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action;
O. The remedies up to, and including, revocation of the Subcontract available to the Contractor if the Subcontractor does not fulfill its obligations;
P. Contain provisions that suspected fraud and abuse be reported to the Contractor.

The requirements of this section would be applicable to contracts with Subcontractors characterized as risk contracts.

The requirements of this section shall not apply to Subcontracts for administrative services or other vendor contracts that do not provide Covered Services to Enrollees.

6.3 Disclosure of Subcontractors

The Contractor shall inform the Department of any Subcontractor providing Covered Services which engages another Subcontractor in any transaction or series of transactions, in performance of any term of this Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense.

6.4 Remedies

FAC and the Department shall each have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract.

6.5 Capitation Agreements

The Contractor shall notify the Department of any "capitation" agreement with Subcontractors or Providers that includes the assumption of risk by the Subcontractor or Provider. The notification shall include the name of the entity, the scope of the risk, the contracting amount, and how the entity in turn pays its Subcontractors or Providers for providing Covered Services. Contractor shall submit monthly reports of Capitation payments made to Subcontractors, such as a vision or pharmacy benefit manager or Providers such as Primary Care Physicians. The Contractor shall mark records it considers proprietary as such and shall defend such classification in the event an Open Records request is made concerning the proprietary record.

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7.0 Contract Term

7.1 Term

The term of the Contract shall be for the period July 1, 2018 through June 30, 2019. This Contract may be renewed for one (1) additional six (6) month period upon the mutual agreement of the Parties. Such mutual agreement shall take the form of an addendum to the Contract under Section 41.3 "**Amendments.**" Contractor shall give notice to the Commonwealth at least sixty (60) days before the end of any annual term if the Contractor does not intend to renew the Contract. The Department shall use its best efforts to provide rates for renewal terms at least ninety (90) days prior to the expiration of the current term, unless the Department elects not to renew the Contract hereunder.

The Commonwealth reserves the right not to exercise any or all renewal options. The Commonwealth reserves the right to extend the Contract for a period less than the length of the above-referenced renewal period if such an extension is determined by FAC and the Department to be in the best interest of the Commonwealth and agreed to by the Contractor.

The Commonwealth reserves the right to renegotiate any terms and/or conditions as may be necessary to meet requirements for the renewal period. In the event proposed terms or conditions cannot be agreed upon, subject to the notices above, either party shall have the right to withdraw without prejudice from exercising the option for a renewal.

7.2 Effective Date

This Contract is not effective and binding until approved by the Commonwealth of Kentucky. Payment under this Contract is contingent upon approval by CMS of any Waiver Amendment, State Plan Amendment and this Contract.

7.3 Social Security

The parties are cognizant that the Commonwealth is not liable for Social Security contributions pursuant to 42 U.S. Code Section 418, relative to the compensation of the Contractor for this Contract.

7.4 Contractor Attestation

The Chief Executive Officer (CEO), the Chief Financial Officer (CFO) or Designee shall attest to the best of their knowledge to the truthfulness, accuracy, and completeness of all data submitted to the Department at the time of submission. This includes encounter data or any other data in which the contractor paid Claims.

8.0 Readiness Review

8.1 Prerequisite to Enrolling Enrollees

The Department reserves the right to conduct an on-or-off-site readiness review prior to the enrollment of Medicaid Enrollees with the Contractor. The purpose of the review is to provide the Department with assurances the Contractor is able and prepared to perform all administrative functions and to provide high-quality services to enrolled Enrollees. Specifically, the review will assess the Contractor's ability to meet the requirements set forth in the Contract and federal requirements outlined in 42 C.F.R. 438 and shall include at a minimum:

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A. A review of the Contractor's ability to provide services to Medicaid Enrollees;
B. A review of an adequate statewide network of providers;
C. A review of the Contractor's QI/UM function capability;
D. A review of the Contractor's ability to provide adequate, accessible PCP and Specialty Providers;
E. A review of the Contractor's technical capacity to process claims and pay providers and respond to Enrollee's needs and send/receive files as required by the Department; and
F. A review of the Contractor's ability to process complaints, grievances and appeals.

The readiness review activities will be conducted by a team appointed by the Department and may include contract staff.

A Contractor's failure to pass the readiness review within ninety (90) days of the execution of a Contract may be in default and may result in Contract termination pursuant to Section 40.7 "**Termination for Default**."

The Department will provide the Contractor with a summary of the findings as well as the areas requiring remedial attention.

8.2 Kentucky HEALTH 1115 Waiver

The Contractor shall complete all readiness review requirements for Kentucky HEALTH, as specified in Section 42 herein.

9.0 Organization and Collaboration

9.1 Office in the Commonwealth

The Contractor shall maintain an office within Kentucky, no more than eighty (80) miles from 275 East Main Street, Frankfort, Kentucky. Such office shall, at a minimum, provide for the following staff functions:

A. Executive Director for the Kentucky account;
B. Enrollee Services for Grievances and Appeals;
C. Provider Services for Provider Relations and Enrollment;
D. Medical Director to oversee the Contractor's clinical functions and the Medically Frail portion of Kentucky HEALTH; and
E. Pharmacy Director to oversee the Contractor's pharmacy program.

Other functions required to be available may be located outside of an eighty (80) mile radius of Frankfort, Kentucky. The Contractor shall not be located outside of the United States. Additionally, no claims paid by the Contractor to a network provider, out-of-network provider, subcontractor, or financial institution located outside of the United States shall be considered in the development of actuarially-sound capitation rates.

The Contractor may subcontract for any functions; however, the above functions, if subcontracted, shall be approved by the Department and shall be carried out within an eighty (80) mile radius of Frankfort, Kentucky within Kentucky. All Subcontractors shall meet appropriate licensing and contract requirements specified in applicable State and Federal laws and regulations.

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9.2 Administration/Staffing

The Contractor shall provide the functions and positions that shall be staffed by a sufficient number of qualified individuals to adequately provide for the Contractor's enrollment or projected enrollment. Responsibility for the functions or staff positions may be combined or divided among departments, individuals, or subcontractors unless otherwise specified. For the purposes of this Contract, the Contractor's Executive Management shall consist of the Executive Director, Finance Director, Medical Director, Pharmacy Director, Dental Director, Behavioral Health Director, Compliance Director and Quality Improvement Director; shall be based in Kentucky; and shall be capable and responsible for oversight of all operations of the Contractor. The Contractor's staff shall have the following minimum responsibilities:

A. A Medical Director, who shall be a physician licensed to practice in Kentucky. The Medical Director shall be actively involved in all major health programs of the Contractor. The Medical director shall also be responsible for treatment policies, protocols, Quality Improvement activities and Utilization Management decisions and devote sufficient time to ensuring timely medical decisions. The Medical Director shall also be available for after-hours consultation, if needed.
B. A Dental Director licensed to practice dentistry in Kentucky. The Dental Director shall be actively involved in all oral health programs of the Contractor and devote sufficient time to ensuring timely oral health decisions. The Dental Director shall also be available for after-hours consultation, if needed.
C. A Finance Officer, who shall oversee the budget and accounting systems implemented by the Contractor.
D. An Enrollee Services function, which coordinates all communications with Enrollees and acts as an advocate for Enrollees. This function shall include sufficient Enrollee Services staff to respond in a timely manner to Enrollees seeking prompt resolution of problems or inquiries.
E. A Provider Services function, which coordinates all communications with Contractor Providers and Subcontractors. This function shall include sufficient Provider Services staff to respond in a timely manner to Providers seeking prompt resolution of problems or inquiries.
F. A Quality Improvement Director, who shall be responsible for the operation of the Contractor's Quality Improvement Program and any subcontractors of the Contractor.
G. A Behavioral Health Director, who shall be a behavioral health practitioner and actively involved in all programs or initiatives relating to behavioral health. The Behavioral Health Director shall also coordinate efforts to provide behavioral health services by the Contractor or any behavioral health subcontractors.
H. A Case Management Coordinator, who shall be responsible for coordination and oversight of case management services and continuity of care for Contractor Enrollees.
I. An Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Coordinator, who shall coordinate and arrange for the provision of EPSDT services and EPSDT special services for Enrollees.
J. A Foster Care and Subsidized Adoption Liaison, who shall be full time and exclusively dedicated to serving as the Contractor's primary liaison for meeting the needs of Enrollees in foster care and subsidized adoption.
K. A Guardianship Liaison, who shall serve as the Contractor's primary liaison for meeting the needs of Enrollees who are adult guardianship clients.
L. A Management Information System Director, who shall oversee, manage and maintain the Contractor management information system (MIS).
M. A Claims Processing function, which shall ensure the timely and accurate processing of claims, including original claims, corrected claims, and re-submissions, and the overall adjudication of claims, including the timely and accurate submission of Encounter data.
N. A Program Integrity Coordinator, who shall be located in Kentucky and whose job duties are dedicated exclusively to the coordination, management, and oversight of the Contractor's

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Program Integrity unit to reduce fraud, waste and abuse of Medicaid services within Kentucky.

O. A Pharmacy Director, who shall coordinate, manage and oversee the provision of pharmacy services to Enrollees.

P. A Compliance Director, who shall maintain current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to Contractors, and oversee the Contractor's compliance with the laws and requirements of the Department. The Compliance Director shall also serve as the primary contact for and facilitate communications between Contractor leadership and the Department relating to Contract compliance issues. The Compliance Director shall also oversee Contractor implementation of and evaluate any actions required to correct a deficiency or address noncompliance with Contract requirements as identified by the Department.

The Contractor shall submit to the Department on an annual basis and upon request by the Department, a current organizational chart depicting all functions including mandatory functions, number of employees in each functional department and key managers responsible for the functions. The Contractor shall notify the Department in writing of any change in the Executive Management within ten (10) business days. The Commonwealth reserves the right to approve or disapprove all key personnel (initial or replacement) prior to their assignment with the Contractor. The Contractor shall ensure that all staff, Providers and Subcontractors have appropriate training, education, experience, liability coverage and orientation to fulfill the requirements of their positions.

Contractor shall provide notice to the Department of any changes relating to the personnel of its management staff, including a change in duties or time commitments. Contractor shall assure the adequacy of its administrator's staffing to properly service the needs of Contractor if changes are proposed in the personnel, duties or time commitments of administrator's staff from those in place on the Effective Date of each Contract. Contractor shall provide those assurances to the Department before permitting its administrator to implement such changes.

9.3 Monthly Meetings

The Contractor's Pharmacy Director, Medical Director, Dental Director and Behavioral Health Director, or their designees, shall meet in separate monthly meetings with the Department and with the other Managed Care Organizations' like personnel to discuss issues for the efficient and economical delivery of quality services to the Enrollees. Contractor shall not be required to discuss or provide proprietary, confidential, or other competitively sensitive information. Such meetings shall be conducted in compliance with applicable federal antitrust laws. The Department may cancel or reduce the meetings, as needed, with prior notice to the Contractor.

10.0 Capitation Payment Information

10.1 Monthly Payment

On or before the eighth (8th) day of each month during the term of this Contract, the Department shall remit to the Contractor the Capitation Payment specified in **Appendix A "Capitation Payment Rates" (subject to approval of the rates by CMS and Appendix A-1)** for each Enrollee determined to be enrolled for the upcoming month. The Contractor shall reconcile the capitation payment against the HIPAA 820. The Contractor shall receive a full month's capitation payment for the month in which enrollment occurs except for an Enrollee enrolled based on a determination of eligibility due to being unemployed in accordance with 45 C.F.R. 233.100. The monthly capitation payment for such an Enrollee shall be pro-rated from the date of eligibility based on unemployment. The Commonwealth's payment shall conform to KRS 45A.245.

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Pursuant to Section 11.2 and because of the delay in the implementation of the Kentucky HEALTH waiver, the Contractor shall be paid the rates reflected in Appendix A-2, from July 1, 2018 to March 31, 2019. The Commonwealth will reconcile the newly certified rates with the rates paid from July 1, 2018, within 45 days of certification.

Upon the implementation of Kentucky HEALTH, the Contractor shall be paid the rates reflected in Appendix A, unless the certification for those rates has expired. If the certification of the rates has expired, the Contractor shall receive the rates reflected in Appendix A-2, until such time as new rates are certified. Upon certification of the rates by the Commonwealth's actuary, the Contractor shall receive the newly certified rates. The Commonwealth will reconcile the newly certified rates from the date of implementation of Kentucky HEALTH to the rates paid, within 45 days of certification.

All rates are subject to change based on the certification from the Contractor's actuary and approval of CMS.

The Department reserves the right, if needed, to delay the monthly payment due on or before June 8 to on or before July 8 or the next business day following July 8. If such delay is contemplated, the Department shall give notice of such intent forty-five (45) days before June 8. Whether or not the Department exercises its right to delay the June Capitation Payment, the payment of all other monthly Capitation Payments shall be made on or before the eighth day of the month in which it is due.

10.2 Payment in Full

The Contractor shall accept the Capitation Payment and any adjustments made pursuant to Section 11.2 "**Rate Adjustments"** of this Contract from the Department as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated with performance of this Contract. Enrollees shall be entitled to receive all Covered Services for the entire period for which the Department has made payment. Any and all costs incurred by the Contractor in excess of the Capitation Payment shall be borne in full by the Contractor. Interest generated through investment of funds paid to the Contractor pursuant to this Contract shall be the property of the Contractor to use for eligible expenditures under this Contract. The Contractor and Department acknowledge that contracts for Medicaid capitated rates and services are subject to approval by CMS.

Contractor may pursue any unpaid Capitation Payment thirty (30) business days after when due from the Commonwealth in accordance with KRS 45A.245.

The Contractor shall report to the Department within sixty (60) calendar days when it has identified capitation payments or other payments in excess of amounts specified in this Contract in accordance with 42 C.F.R. 438.608(c)(3).

10.3 Payment Adjustments

Effective starting with the January 2017 Monthly Capitation Payment, the Monthly Capitation Payments shall be adjusted for a period not to exceed twenty-four (24) months prior to the Monthly Capitation Payment to reflect corrections to the Enrollee Listing Report. Payments will be adjusted to reflect the automatic enrollment of eligible newborn infants. Claims for payment adjustments shall be deemed to have been waived by the Contractor if a payment request is not submitted in writing within twelve (12) months following the month for which an adjustment is requested. Waiver of a claim for payment shall not release the Contractor of its obligations to provide Covered Services pursuant to the Contract.

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In the event that an Enrollee is eligible and enrolled, but does not appear on the Enrollee Listing Report, the Contractor may submit a payment adjustment request. The request is to be submitted in accordance with Report 230 automated reporting requirements.

In the event that an Enrollee is eligible and enrolled and the Contractor believes the capitation payment was in error due to underpayment, overpayment or duplicate payment, the Contractor may submit a payment adjustment request. The request is to be submitted in accordance with Report 250 automated reporting requirements.

In the event that an Enrollee does not appear on the Enrollee Listing Report, but the Department has paid the Contractor for an Enrollee, the Department may request and obtain a refund of, or it may recoup from subsequent payments, any payment previously made to the Contractor.

In the event an Enrollee appears on the Enrollee Listing Report but is determined to be ineligible, the Department may request and obtain a refund of, or it may recoup from subsequent payments, any payment previously made to the Contractor. In such instances, for each Enrollee that is determined to be ineligible, the Contractor may recover payment from any Provider who rendered services to Enrollee during the period of ineligibility. The entity to which the Enrollee is retroactively added shall assume responsibility for payment of any services provided to Enrollees during the period of adjusted eligibility.

For cases involving Enrollee ineligibility due to fraud, waste and abuse, the Department shall only recoup the capitation amount and the Contractor shall establish procedures pursuant to Section 10.4 "**Contractor Recoupment from Enrollee for Fraud, Waste and Abuse**" to recover paid Claims. Any adjustment by the Department hereunder for retroactive disenrollments of Enrollees shall not exceed twelve (12) months from the effective date of disenrollment.

10.4 Contractor Recoupment from Enrollee for Fraud, Waste and Abuse

If permitted by state and federal law, the Contractor shall request a refund from the Enrollee for all paid Claims in the event the Department has established that the Enrollee was not eligible to be enrolled through an administrative determination or adjudication of fraud. The Contractor shall, upon receipt of a completed OIG investigation of a Contractor's Enrollee that calls for administrative recoupment, send a request letter to Enrollee seeking voluntary repayment of all claims paid by contractor on behalf of Enrollee during time period Enrollee was found to be ineligible to receive services. The request letter shall include the following as provided by the Department: the reason for the Enrollee's ineligibility, time period of ineligibility, and amount paid during the period of ineligibility. The Contractor shall report, on a monthly basis, to the Commonwealth any monies collected from administrative request letters during the previous month and provide a listing of all administrative request letters sent to Enrollees(s) during the previous month. The Contractor is only required to mail the initial letter to the Enrollee requesting repayment of funds and accept repayment on behalf of the Department. The contractor is not required to address any due process issues should those arise. The Contractor shall work with Department's agent to obtain monies collected through court ordered payments. Any outstanding payments not collected within six (6) months shall be subject to be collected by the Commonwealth and shall be maintained by the Commonwealth. The foregoing provisions shall be construed to require Contractor's reasonable cooperation with the Commonwealth in its efforts to recover payments made on behalf of ineligible persons, and shall not create any liability on the part of the Contractor to reimburse amounts paid due to fraud that the Contractor has been unable to recover.

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11.0 Rate Component

11.1 Calculation of Rates

The Capitation Rate has been established in accordance with 42 C.F.R. 438. The Capitation Rates are attached as **Appendix A. "Capitation Payment Rates"** and shall be deemed incorporated into this Contract and shall be binding to the Contractor and the Department, subject to CMS' approval. If CMS fails to approve a component of the rates, the capitation payment rates shall be adjusted to reflect that disapproval.

11.2 Rate Adjustments

Prospective adjustments to the rates may be required if there are mandated changes in Medicaid services to the managed care population provided through this Contract as a result of legislative, executive, regulatory, or judicial action. Changes applicable to this Contract mandated by state or federal legislation, or executive, regulatory or judicial mandates, shall take effect on the dates specified in the legislation or mandate. In the event of such changes, any rate adjustments shall be made through the Contract amendment process.

Contractors are free to negotiate provider rates and methodologies that are tied to Medicaid fee-for-service reimbursement, but such ties shall not be considered to have any direct impact on rates. Changes to fee-for-service provider reimbursement rates or methodologies which may be mandated by legislative, executive, regulatory or judicial action shall not be considered as an impact to the Contractor that must be considered in setting and/or adjusting rates unless those changes are explicitly required under this Contract.

11.3 Health Insurers' Premium Fee under the ACA

The health insurers' premium fee (HIF) under the ACA is due in September for the preceding calendar year premiums each year unless otherwise modified. If the Contractor is or will be subject to the health insurer's premium fee for the Capitation Payments being made under this or a previously existing Managed Care Contract with the Commonwealth, the Commonwealth shall compensate the Contractor for that fee and for any federal taxes resulting from such compensation. To facilitate this payment, the Contractor shall provide the Department with the Insurer's Premium Fee assessment received from the Federal Government and the pro rata portion attributed to the Contractor's Capitation Payments under its Contract(s) for the preceding calendar year if available. In addition, the Contractor shall provide a certified statement from its Chief Financial Officer as to the effective Federal Tax Rate paid for the past five tax periods. These shall be submitted to the Department no later than September 1 of each year that the Insurer's premium fee is imposed. This payment method is contingent upon receipt of federal financial participation for the payment and CMS approval.

11.4 Medical Loss Ratio Adjustment

Beginning with State Fiscal Year 2017 and continuing annually on a state fiscal year basis thereafter, the total annual capitation payment made to the Contractor for the combined ACA and Non-ACA populations and their associated healthcare costs shall be evaluated against a ninety (90) percent Minimum Medical Loss Ratio Requirement to determine whether a Payment Adjustment is warranted (determined pursuant to **Appendix B** "**Medical Loss Ratio Calculation")**. A Payment Adjustment (premium refund) shall occur if:

A. The Contractor has a Medical Loss Ratio of less than 90% but greater than or equal to eighty-six (86) percent. The Contractor shall submit a Payment Adjustment (premium refund) to the Commonwealth for seventy-five (75) percent of the difference between the

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dollar amount corresponding to actual medical loss ratio and the dollar amount corresponding to a 90% Medical Loss Ratio.

B. The Contractor has a Medical Loss Ratio less than 86%. The Contractor shall submit a Payment Adjustment (premium refund) to the Commonwealth for the sum of: (a) 75% of the difference between the dollar amount corresponding to an 86% medical loss ratio and the dollar amount corresponding to a 90% loss ratio; and (b) one hundred (100) percent of the difference between the actual countable medical expenses for the Contractor and the dollar amount corresponding to an 86% medical loss ratio.

The adjustment process will begin ten (10) months after the end of each State Fiscal Year. If the Contract with the Contractor is not renewed at any time or is terminated at any time, the Medical Loss Ratio and Annual Statement will reflect an appropriately reduced number of months of experience instead of the full twelve (12) months.

As part of the financial reconciliation process described above, the Contractor shall calculate and report an MLR in a format and manner prescribed by the Department for expenses directly attributed or allocated for both the ACA and non-ACA combined beginning with State Fiscal Year 2017 and continuing annually on a state fiscal year basis thereafter. The report shall be in compliance with 42 C.F.R. 438.8(k) and shall include an attestation from the Contractor's actuary to the accuracy of the calculation in accordance with the requirements of 42 C.F.R. 438.8. The Contractor shall require Subcontractors/vendors providing claim adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting period or within thirty (30) days of Contractor's request for such information. The report, and any other information the Contractor wants to submit for consideration, shall be due to the Commonwealth thirty (30) calendar days after the end of the 12-month period described above.

The Commonwealth shall then determine, within 30 days of receipt of all information from all Contractors, if any adjustment is to be collected and notify the Contractor in writing. The Contractor shall then have fifteen (15) days to review the Commonwealth's findings and remit payment to the Commonwealth. Items for reconciliation, including non-claim specific items, are further described in **Appendix B "Medical Loss Ratio Calculation"** of this Contract. The calculation of the Medical Loss Ratio shall comply with the requirements of 42 C.F.R. 438.8. The Contractor shall cooperate with the Department or its contractor by supplying all clarifications and answers to inquiries within the requested timeframe. If the Contractor fails to submit information or respond to a Department request regarding Medical Loss Ratio Calculation within the requested timeframe, it shall be subject to a penalty of $500.00 per day until the information or response is received.

If the Department makes a retroactive change to a capitation payment in a MLR reporting year that has already been submitted, upon the Department's request, the Contractor shall recalculate the MLR for any year affected by the change and submit a new MLR report meeting the applicable requirements

11.5 Physician Incentive Plans

A template for any compensation arrangement between the Contractor and a physician, or physician group as that term is defined in 42 C.F.R. § 417.479(c); or between the Contractor and any other Primary Care Providers within the meaning of this Contract; or between the Contractor and any other Subcontractor (or like entity) shall be submitted to the Department for approval prior to its implementation. Approval is preconditioned on compliance with all applicable federal and Commonwealth laws and regulations and subject to Section 4.4 "**Approval of Department**." The Contractor shall provide information to any Enrollee upon request about any Physician Incentive Plan and/or any payments to Provider made pursuant to an incentive arrangement under this Section to a provider as required by applicable state or federal law.

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11.6 Contractor Provider Payments

If a Contractor includes a Physician Incentive Plan, the activities included shall comply with requirements set forth in 42 C.F.R. 422.208 and 42 C.F.R. 422.210. The Disclosures to the Department for Contractors with Physician Incentive Plans shall include the following:

A. The Contractor shall report whether services not furnished by a physician/group are covered by the incentive plan. No further disclosure is required if the Physician Incentive Payment does not cover services not furnished by a physician/group.
B. The Contractor shall report type of incentive arrangement, e.g. withhold, bonus, capitation.
C. The Contractor shall report percent of withhold or bonus (if applicable).
D. The Contractor shall report panel size, and if patients are pooled, the approved method used.
E. If the physician/group is at substantial financial risk, the Contractor shall report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

11.7 Co-Pays

If Contractor implements co-pays, those co-pays shall not exceed the Department's Fee for Service co-pays. The Contractor shall report on the Enrollees usage and co-payments, including recognition of the accumulation indicators for maximum out-of-pocket co-payments and cost sharing capitations per period that are shared through system files transmissions. The co-payment requirements for the Medicaid Program can be found in 907 KAR 1:604. Any cost sharing imposed by the Contractor shall be in accordance with 42 C.F.R. §§447.50 through 447.82.

Whether the Contractor imposes such co-pays or not, the actuarial value of the co-pays will be reflected in the Capitation Rate.

The Department may, at its discretion, mandate the imposition or collection of co-pays with at least ninety (90) days written notice to the Contractor.

12.0 Risk Adjustments

12.1 Purpose for Risk Adjustments

Risk adjustment uses information on an Enrollee's medical conditions, as reported in claims data, to predict health care costs and adjust payments to MCOs. Risk adjustment helps ensure payments to MCOs are more equitable and mitigates the impact of selection bias, thus protecting MCO solvency and reducing incentives for plans to avoid high-risk individuals. Risk adjustment is designed to be revenue neutral to the State.

12.2 Risk Adjustment Method

The capitation rates will be risk-adjusted on a prospective basis as described below:

A. Risk Adjustment Model

The CDPS + Rx model will be used. In general, the most recent available version of the model will be applied, though there may be circumstances in which an older version is preferred. Concurrent weights will be used to develop the risk profiles of Enrollees.

B. Calibration of Risk Weights

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The Department shall phase in the calibration of risk weights over a fifteen (15) month period, with the full implementation of Kentucky–specific weights to be initiated on October 1, 2019.

C. Rate Cells excluded from Risk Adjustment

Dual Eligible rate cells are excluded from the risk adjustment calculation. Additional rate cells may also be excluded depending on changes in rate cell structure. Examples may include delivery payment and newborns.

D. Minimum Eligibility to Receive Risk Score

The minimum length of eligibility, which eligibility need not be continuous, during the risk analysis period in order for risk score to be considered in the MCO risk adjustment calculation is three months. Exceptions may apply for newborns and pregnant women.

Enrollees who do not receive a risk score shall be assigned a risk score that reflects the average risk for their rate cell, region, and MCO. Risk scores for these enrollees may be adjusted to reflect the individuals' demographic scores.

E. Risk Score Calculation

Twelve months of managed care encounter and fee-for-service claims data, excluding laboratory and x-ray claims, will be run through the risk model to calculate a risk score for each individual. Months of Medicaid eligibility during the 12-month analysis period are also calculated. Individual risk scores will be attributed to each MCO based on the MCO in which the person is enrolled as of a specific point in time. Raw risk scores and Enrollee months will be aggregated by rate cell, and attributed to the MCO, and relative risk adjustment scores will be calculated.

F. Payment Adjustment

Payment adjustments will be calculated by applying the risk adjustment scores to the negotiated capitation rates by rate cell.

G. Provider Settlements (Supplemental Pass-Through Payments)

Since MCO provider settlement obligations are a fixed amount each month, the per capita value of the settlement obligations is removed from each MCO's contracted rates prior to applying risk adjustment, and are added back in after applying risk adjustment.

H. Timing and Frequency

In general, 12 months of recent, reasonably complete data will be analyzed to develop the risk scores. Risk measurement periods will be set to provide a reasonable amount of claims runout. The Department will make updates to the risk scores at least twice per state fiscal year, either in the form of a full Enrollee re-score or an update for changes in Enrollee distributions, with all calculations including a budget neutrality adjustment.

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13.0 Contractor's Financial Security Obligations

13.1 Solvency Requirements and Protections

The Contractor shall be subject to requirements contained in KRS Chapter 304 and related administrative regulations regarding protection against insolvency and risk-based capital requirements. In addition, pursuant to KRS 304.3-125, the Commissioner has authority to require additional capital and surplus if it appears that an insurer is in a financially hazardous condition.

The Contractor shall cover continuation of services to Enrollees during insolvency, for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge.

In the event of the Contractor's insolvency, the Contractor shall not hold its Enrollees liable, except in instances of Enrollee fraud:

A. For the Contractor's debts;
B. For the covered services provided to the Enrollee, for which the Department does not pay the Contractor;
C. For the covered services provided to the Enrollee for which the Department or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; and
D. For covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if the Contractor provided the services directly.

13.2 Contractor Indemnity

In no event shall the Commonwealth, FAC, the Department or Enrollee be liable for the payment of any debt or fulfillment of any obligation of the Contractor or any Subcontractor to any Subcontractor, supplier, Out-of-Network Provider or any other party, for any reason whatsoever, including the insolvency of the Contractor or any Subcontractor. The Contractor agrees that any Subcontract will contain a hold harmless provision.

The Contractor shall indemnify, defend, save and hold harmless the Commonwealth, FAC, the Department, its officers, agents, and employees (collectively, the "Indemnified Parties") from all claims, demands, liabilities, suits, judgments, or damages, including court costs and reasonable attorney fees made or asserted against or assessed to the Indemnified Parties (collectively the "Losses"), arising out of or connected in any way with this Contract or the performance or nonperformance by the Contractor, its officers, agents, employees; and suppliers, Subcontractors, or Providers, including without limitation any claim attributable to:

A. The improper performance of any service, or improper provision of any materials or supplies, irrespective of whether the Department knew or should have known such service, supplies or materials were improper or defective;
B. The erroneous or negligent acts or omissions, including without limitation, disregard of federal or Commonwealth law or regulations, irrespective of whether the Department knew or should have known of such erroneous or negligent acts;
C. The publication, translation, reproduction, delivery, collection, data processing, use, or disposition of any information to which access is obtained pursuant to this Contract in a manner not authorized by this Contract or by federal or Commonwealth law or regulations, irrespective of whether the Department knew or should have known of such publication, translation, reproduction, delivery, collection, data processing, use, or disposition; or
D. Any failure to observe federal or Commonwealth law or regulations, including but not limited

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to, insurance and labor laws, irrespective of whether the Department knew or should have known of such failure.

Upon receiving notice, the Department shall give the Contractor written notice of any claim made against the Contractor for which the Indemnified Parties are entitled to indemnification, so that the Contractor shall have the opportunity to appear and defend such claim. The Indemnified Parties shall have the right to intervene in any proceeding or negotiation respecting a claim and to procure independent representation, all at the sole cost and expense of the Indemnified Parties. Under no circumstances shall the Contractor be deemed to have the right to represent the Commonwealth in any legal matter without express written permission from FAC. Notwithstanding the above, Contractor shall have no obligation to indemnify the Indemnified Parties for any losses due to the negligent acts or omissions or intentional misconduct of the Indemnified Parties.

13.3 Insurance

The Contractor shall secure and maintain during the entire term of the Contract, and for any additional periods following termination of the Contract during which it is obligated to perform any obligations pursuant to this Contract, original, prepaid policies of insurance, in amounts, form and substance satisfactory to FAC, and non-cancelable except upon thirty (30) days prior written notice to FAC, providing coverage for property damage (all risks), business interruption, comprehensive general liability, motor vehicles, workers' compensation and such additional coverage as is reasonable or customary for the conduct of the Contractor's business in the Commonwealth.

13.4 Advances and Loans

The Contractor shall not, without thirty (30) days prior written notice to and approval by the Department, make any advances to a related party or Subcontractor. The Contractor shall not, without similar thirty (30) day prior written notice and approval, make any loan or loan guarantee to any entity, including another fund or line of business within its organization. Such approval is subject to Section 4.4 "**Approval of Department**." Written notice is to be submitted to the Department and if applicable to DOI. The prohibition on advances to Subcontractors contained in this subsection shall not apply to Capitation Payments or payments made by the Contractor to Contractor's Network for provision of Covered Services.

13.5 Provider Risks

If a Provider assumes substantial financial risk for contracted services, the Contractor shall ensure that the Provider has adequate stop-loss protection. The Contractor shall provide the Department proof the Provider has adequate stop-loss coverage, including an amount and type of stop-loss.

14.0 Third Party Resources

14.1 Coordination of Benefits (COB)

The Contractor shall actively pursue, collect and retain all monies available from all available resources for services to Enrollees under this Contract except where the amount of reimbursement the Contractor can reasonably expect to receive is less than estimated cost of recovery.

Cost effectiveness of recovery is determined by, but not limited to, time, effort, and capital outlay required in performing the activity. The Contractor shall specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party, or

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describe the process by which the Contractor determines seeking reimbursement would not be cost effective. The Contractor shall provide the guidelines to the Department for review and approval.

COB collections are the responsibility of the Contractor or its Subcontractors. Subcontractors shall report COB information to the Contractor. Contractor and Subcontractors shall not pursue collection from the Enrollee but directly from the third party payer. The Contractor shall only recoup payments to providers if the third party payer is Medicare. Access to Covered Services shall not be restricted due to COB collection. The Contractor will be subject to penalty should any Enrollee be denied access to Covered Services due to COB collection.

The Contractor shall maintain records of all COB collections. The Contractor shall demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. The Department has the right to review all billing histories and other data related to COB activities for Enrollees. The Contractor shall seek information on other available resources from all Enrollees.

In order to comply with CMS reporting requirements, the Contractor shall submit a monthly COB Report for all Enrollee activity which the Department or its agent shall audit no less than every six (6) months. Additionally, Contractor shall submit a report that includes subrogation collections from auto, homeowners, or malpractice insurance, etc.

14.2 Third Party Liability

By law, Medicaid is the payer of last resort and as a result shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. If an Enrollee has resources available for payment of expenses associated with the provision of Covered Services, other than those which are exempt under Title XIX of the Social Security Act, such resources are primary to the coverage provided by the Contractor, pursuant to this Contract, and must be exhausted prior to payment by the Contractor. The Capitation Rate set forth in this Contract has been adjusted to account for the primary liability of third parties to pay such expenses. The Contractor shall be responsible for determining the legal liability of third parties to pay for services rendered to Enrollees pursuant to this Contract. The Contractor shall maintain a current TPL Resource File which contains the Enrollee's current TPL information including coverage that has ended for the Enrollee. All funds recovered by the Contractor from Third Party Resources shall be treated as income to the Contractor to be used for eligible expenses under this Contract. Except as provided in Section 42, the Contractor and all Providers in the Contractor's Network are prohibited from directly receiving payment or any type of compensation from the Enrollee, except for Enrollee co-pays or deductibles from Enrollees for providing Covered Services. Enrollee co-pay, co-insurance or deductible amounts cannot exceed amounts specified in 907 KAR 1:604. Co-pays, co-insurance or deductible amounts may be increased only with the approval of the Department.

42 C.F.R. 433.138 requires that as a condition of Medicaid eligibility each Enrollee will be required to:

A. Assign, in writing, his/her rights to the Contractor for any medical support or other Third Party Payments for medical services paid for by the Contractor; and
B. Cooperate in identifying and providing information to assist the Contractor in pursuing third parties that may be liable to pay for care and services.

42 C.F.R. 433.138 requires the Contractor be responsible for actively seeking and identifying third party resources, i.e. health or casualty insurance, liability insurance and attorneys retained for tort action, through contact with the Enrollees, participating providers, and the Medicaid Agency. However, the Commonwealth may direct the Contractor to refrain from actively seeking and

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identifying third party resources for services that are covered only by the Medicaid program, as identified by the Department.

42 C.F.R. 433.139 requires the Contractor be responsible to assure that the Medicaid Program is the payer of last resort when other Third Party Resources are available to cover the costs of medical services provided to Medicaid Enrollees. When the Contractor is aware of other Third Party Resources, the Contractor shall avoid payment by "cost avoiding" (denying) the Claim and redirecting the provider to bill the other Third Party Resource as a primary payer. If the Contractor does not become aware of another Third Party Resource until after the payment for service, the Contractor is responsible to seek recovery from the Third Party Resource on a post-payment basis. See **Appendix C. "Third Party Payments/Coordination of Benefits**." The Department or its agent will audit the Contractor's Third Party practices and collections at least every six (6) months.

The Contractor shall respond to Enrollee and provider requests for COB or TPL updates according to the following timelines:

A. For urgent requests, within forty-eight (48) hours; or
B. For routine requests, within three (3) business days.

15.0 Management Information System

15.1 Contractor MIS

The Contractor shall maintain a Management Information System (MIS) that will provide support for all aspects of a managed care operation to include the following subsystems: Enrollee, third party liability, provider, reference, encounter/Claims processing, financial, utilization data/quality improvement and Surveillance Utilization Review Subsystem. The Contractor will also be required to demonstrate sufficient analysis and interface capacities. The Contractor's MIS shall ensure medical information will be kept confidential at all times including but not limited to when data is moving and at rest, through security protocol, especially as that information relates to personal identifiers and sensitive services. The Contractor shall comply with 42 C.F.R. 438.242.

The Contractor shall provide such information in accordance with the format and file specifications for all data elements as specified in **Appendix D. "Management Information Systems Requirements"** hereto, and as may be amended from time to time.

The Contractor shall transmit all data directly to the Department in accordance with 42 C.F.R. 438. If the Contractor utilizes subcontractors for services, all data from the subcontractors shall be provided to the Contractor and the Contractor shall be responsible for transmitting the subcontractors' data to the Department in a format specified by the Department in accordance with 42 C.F.R. 438.

The Contractor will execute a Business Associate Agreement (BAA) in **Appendix E. "Business Associates Agreement"** with the Department, pursuant to Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as "the Administrative Simplification provisions," direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information. The execution of the BAA is required prior to data exchanges being implemented.

The Contractor shall be responsible for meeting all system requirements, including but not limited to required testing, as directed by the Department. Upon request by the Department, the Contractor's participation in Joint Application Development sessions for system or policy changes shall be required.

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At least ten days prior to implementation, the Contractor shall notify the Department of any significant changes to the system that may impact the integrity of the data, including such changes as new Claims processing software, new Claims processing vendors and significant changes in personnel.

15.2 Contractor MIS Requirements

The Department's MIS system utilizes eight (8) subsystems to carry out the functions of the Medicaid program. The Contractor is not required to have actual subsystems as listed below, provided the requirements are met in other ways which may be mapped to the subsystem concept. The Contractor shall have the capacity to capture necessary data and provide it in formats and files that are consistent with the Commonwealth's functional subsystems as described below. The Contractor shall maintain flexibility to accommodate the Department's needs if a new system is implemented by the Commonwealth. These subsystems focus on the individual systems functions or capabilities which provide support for the following areas:

A. Enrollee Subsystem;
B. Third Party Liability (TPL);
C. Provider Subsystem;
D. Reference Subsystem;
E. Claims Processing Subsystem (to include Encounter Data);
F. Financial Subsystem;
G. Utilization/Quality Improvement Subsystem; and
H. Surveillance Utilization Review Subsystem (SURS).

The Contractor shall ensure that data received from Providers and Subcontractors is accurate and complete by:

A. Verifying, through edits and audits, the accuracy and timeliness of reported data;
B. Screening the data for completeness, logic and consistency;
C. Collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for the Department's Medicaid quality improvement and care coordination efforts;
D. Compiling and storing all Claims and encounter data from the Subcontractors in a data warehouse in a central location in the Contractor's MIS;
E. At a minimum, edits and audits must comply with NCCI;
F. Resolving all reporting errors in transaction submission and reconciliation; and
G. Successfully transmitting required data to the Department.

15.3 Interface Capability

The interface subsystems support incoming and outgoing data from other organizations and allow the Contractor to maintain Enrollee Enrollment information and Enrollee-related information. It might include information from secondary sources to allow the tracking of population outcome data or other population information. At a minimum, there will be a Provider, Enrollee, Encounter Record and capitation interface. Specific requirements for the interface subsystem shall include such items as: defined data elements, formats, and file layouts including input and output job schedule with backend reporting and data reconciliation.

15.4 Access to Contractor's MIS

The Contractor shall provide the Department with log-in credentials in order to access Contractor's claims and customer service systems on a read-only basis at the Contractor's primary place of business during normal business hours. The Contractor shall provide the

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Department access to a locked space and office security credentials for use during business hours. All access under this Section shall comply with HIPAA's minimum necessary standards and any other applicable Commonwealth or federal law.

16.0 Encounter Data

16.1 Encounter Data Submission

The Contractor shall ensure that Encounter data is consistent with the terms of this Contract and all applicable state and federal laws. (See **Appendix F. "Encounter Data Submissions Requirements and Quality Standards**.") The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports and Encounter Files set in formats and timelines prescribed by the Department as defined in the Contract. The system shall be capable of following or tracing an Encounter within its system using a unique Encounter identification number for each Encounter. At a minimum, the Contractor shall be required to electronically provide Encounter Files to the Department, on a weekly schedule. Encounter Files must follow the format, data elements and method of transmission specified by the Department. All changes to edits and processing requirements due to Federal or State law changes shall be provided to the Contractor in writing no less than sixty (60) business days prior to implementation, whenever possible. Other edits and processing requirements shall be provided to the Contractor in writing no less than thirty (30) business days prior to implementation. The Contractor shall submit electronic test data files as required by the Department in the format referenced in this Contract and as specified by the Department. The electronic test files are subject to Department review and approval before production of data. The Department will process the Encounter data through defined edit and audit requirements and reject Encounter data that does not meet its requirements. Threshold edits, those which will enable the Encounter File to be accepted, and informational editing, those which enable the Encounter to be processed, shall apply. The Department reserves the right to change the number of, and the types of edits used for threshold processing based on its review of the Contractor's monthly transmissions. The Contractor shall be given thirty (30) working days' prior notice of the addition/deletion of any of the edits used for threshold editing. The Encounter data will be utilized by the Department for the following:

A. To evaluate access to health care, availability of services, quality of care and cost effectiveness of services;
B. To evaluate contractual performance;
C. To validate required reporting of utilization of services;
D. To develop and evaluate proposed or existing Capitation Rates;
E. To meet CMS Medicaid reporting requirements; and
F. For any purpose the Department deems necessary.
G. For Risk Adjustments
H. For Clinical Performance Measures
I. For Report Card Status
J. For Fraud and Waste observation

Data quality efforts of the Department shall incorporate the following standards for monitoring and validation:

A. Edit each data element on the Encounter for required presence, format, consistency, reasonableness and/or allowable values;
B. Edit for Enrollee eligibility;
C. Perform automated audit processing (e.g. duplicate, conflict, etc.) using history Encounter and same-cycle Encounter data;
D. Identify exact duplicate Encounters;
E. Maintain an audit trail of all error code occurrences linked to a specific Encounter; and
F. Update Encounter history files with both processed and incomplete Encounter data.

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The Contractor shall have the capacity to track all Erred Encounter Records and provide a report detailing transmission reconciliation of each failed transaction or file within 30 calendar days of the transaction or file error.

The Contractor shall be required to use procedure codes, diagnosis codes, MS-DRG, and other codes used for reporting Encounters in accordance with guidelines and versions of all code sets as defined by the Department. The Contractor must also use appropriate NPI/Provider numbers for Encounters as directed by the Department.

The Contractor shall submit corresponding data in all data fields on each encounter file submitted to the Department. Claims shall be submitted with a current and valid date in the format identified by the applicable encounter file submission guidelines.

Encounters submitted without dates, even those that have previously been allowed to be submitted blank shall be populated with a valid date or the encounter shall threshold. A complete list of field requirements at both the detail and the header levels shall be supplied by the Department.

The Encounter File shall be received and processed by the Department's Fiscal Agent and shall be stored in the existing MMIS.

All Subcontracts with Providers or other vendors of service must have provisions requiring that an Encounter is reported/submitted in an accurate and timely fashion.

The Contractor shall specify to the Department the name of the primary contact person assigned responsibility for submitting and correcting Encounters, and a secondary contact person in the event the primary contact person is not available. The Contractor shall report the reconciliation status of failed transactions on a monthly basis.

The Contractor shall be required to submit encounter data after the Contract ends for services rendered during the Contract period for a sufficient time as determined by the Department to ensure timely filing and complete data.

16.2 Technical Workgroup

The Contractor shall assign staff to participate in the Encounter Technical Workgroup periodically scheduled by the Department. The workgroup's purpose is to enhance the data submission requirements and improve the accuracy, quality and completeness of the Encounter submission.

17.0 Kentucky Health Information Exchange (KHIE)

The Contractor shall encourage all Providers in their Network to establish connectivity with the KHIE. For newly contracted providers, the Contractor shall notify the Provider within one month of the recommendation to sign a Participation Agreement with KHIE for the purpose of connecting their electronic health records system to the health information exchange to share their patient electronic records. The data set required for submission is a **Summary of Care Record**.

For hospitals, the Contractor shall also recommend the submission of ADTs (Admission, Discharge, Transfer messages) to KHIE.

If the provider does not have an electronic health record the Contractor will encourage the Provider to sign a Participation Agreement with KHIE as well as sign up for Direct Secure

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Messaging services so that clinical information can be shared securely with other providers in their community of care.

The Department may, at its discretion, mandate provider participation with at least ninety (90) days written notice to the Contractor.

18.0 Electronic Health Records

The Contractor shall encourage all Providers in its Network to participate in the EHR Incentive Program, if eligible.

The Department will continue to administer the EHR Incentive Payment Program. The Department will notify the Contractor on a monthly basis which providers have received incentive payments and will continue to update the Contractor when additional payments are made. The Contractor shall comply with data requests from the Department to assist in verification that the Providers are meeting the requirements for the EHR Incentive Payment Program.

19.0 Quality Assessment/Performance Improvement (QAPI)

19.1 QAPI Program

The Contractor QAPI Program shall conform to requirements of 42 C.F.R. 438, Subpart E. The Contractor shall implement and operate a comprehensive QAPI program that assesses, monitors, evaluates and improves the quality of care provided to Enrollees. The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the Contractor. The Contractor's QI structures and processes shall be planned, systematic and clearly defined. The Contractor's QI activities shall demonstrate the linkage of QI projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified from the annual HEDIS indicators and the consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by an accreditation body. The QAPI program shall be developed in collaboration with input from Enrollees. The Contractor shall maintain documentation of all Enrollee input; response; conduct of performance improvement activities; and feedback to Enrollees. The Contractor shall have or obtain within two (2) to four (4) years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line. The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report every three years including the scoring at the category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Review Tool (IRT): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.

Annually, the Contractor shall submit the QAPI program description document to the Department in accordance with a format and timeline specified by the Department, after consultation with the Contractor. However, the final design shall be decided by the Department. The Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Enrollees. The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Enrollee's overall care. The Contractor shall also have mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

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19.2 Annual QAPI Review

The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Enrollees. The Contractor shall modify as necessary, the QAPI program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes to meet the needs of Enrollees. The Contractor shall prepare a written report to the Department, detailing the annual review and shall include a review of completed and continuing QI activities that address the quality of clinical care and service; trending of measures to assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Enrollees. The Contractor shall submit this report as specified by the Department. The Department shall give the Contractor at least ninety (90) days advance notice of the due date of the annual QAPI report.

19.3 QAPI Plan

The Contractor shall have a written QAPI work plan that outlines the scope of activities and the goals, objectives and timelines for the QAPI program. New goals and objectives must be set at least annually based on findings from quality improvement activities and studies, survey results, Grievances and Appeals, performance measures and EQRO findings. The Contractor is accountable to the Department for the quality of care provided to Enrollees. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI program and annual QAPI work plan; designation of an accountable entity within the organization to provide direct oversight of QAPI; review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made; review on an annual basis of the QAPI program; and modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.

The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program. The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It shall include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care needs. The committee shall meet on a regular basis and activities of the committee must be documented; all committee minutes and reports shall be available to the Department upon request.

QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Record, are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.

The Contractor shall integrate other Management activities such as Utilization Management, Risk Management, Enrollee Services, Grievances and Appeals, Provider Credentialing, and Provider Services in its QAPI program. Qualifications, staffing levels and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities, including but not limited to monitoring and evaluation of Enrollee's care and services, including the care and services of Enrollees with special health care needs; use of preventive services; coordination of behavioral and physical health care needs, monitoring and providing feedback on provider performance, involving Enrollees in QAPI initiatives; underutilization and overutilization

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of services; and conducting performance improvement projects. Written documentation listing staffing resources, including total FTE's percentage of time, experience and roles, shall be submitted to the Department, upon request.

The Contractor shall submit the QAPI work plan to the Department annually in accordance with a format and timeline specified by the Department. The Department shall give the Contractor at least ninety (90) days' advance notice of the due date of the annual QAPI report.

19.4 QAPI Monitoring and Evaluation

The Contractor, through the QAPI program, shall monitor and evaluate the quality of health care on an ongoing basis. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines. Standardized quality indicators shall be used to assess improvement, assure achievement of at least minimum performance levels, monitor adherence to guidelines and identify patterns of over- and under-utilization. The measurement of quality indicators selected by the Contractor must be supported by valid data collection and analysis methods and shall be used to improve clinical care and services.

Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee. Areas identified for improvement shall be tracked and corrective actions taken as indicated. The effectiveness of corrective actions shall be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.

The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues. The Contractor shall collaborate with existing provider quality improvement activities and, to the extent possible, align with those activities to reduce duplication and to maximize outcomes.

The Contractor shall submit to the Department upon request documentation regarding quality and performance improvement (QAPI) projects/performance improvement projects (PIPs) and assessment that relates to enrolled Enrollees. Refer to Section 20.5 "**Performance Improvement Projects"** for further detail.

The Contractor shall develop or adopt practice guidelines that are disseminated to Providers, and, upon request, to Enrollees and Potential Enrollees. Mental Health and Substance Use practice guidelines shall also be submitted to the Department and DBHDID. The guidelines shall be based on valid and reliable medical/behavioral health evidence or consensus of health professionals; consider the needs of Enrollees; developed or adopted in consultation with contracting health professionals, and reviewed and updated periodically. Decisions with respect to UM, Enrollee education, covered services, and other areas to which the practice guidelines apply shall be consistent with the guidelines.

20.0 Kentucky Healthcare Outcomes

20.1 Kentucky Outcomes Measures and Health Care Effectiveness Data and Information Set (HEDIS) Measures

All health goals, outcomes, and indicators shall comply with Federal requirements established under 42 C.F.R. 438.240 (C)(1) and (C)(2) relating to Contractor performance and reporting. The Department shall assess the Contractor's achievement of performance improvement related to the health outcome measures. The Contractor shall be expected to achieve demonstrable and

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sustained improvement for each measure. The Department will set specific quantitative performance targets and goals. The Contractor shall report activities on the performance measures in the QAPI work plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall make comparisons across data for each measure by the Medicaid geographic regions, eligibility category, race ethnicity, gender and age to the extent such information has been provide by the Department to Contractor. This information may be used to determine disparities in health care.

20.2 Reporting HEDIS Performance Measures

The Contractor shall be required to collect and report HEDIS data annually. This data shall include separate data for the KCHIP population. After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than each August 31.

In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures. All submissions shall include a copy to the Department's Division of Program Quality & Outcomes, Managed Care Oversight Quality Branch Manager

For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall make comparisons across each measure by Medicaid Region, Medicaid eligibility category, race, ethnicity, gender and age.

Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS reported measures on which the Department will evaluate the Contractor's performance. The Department shall inform the Contractor of its performance on each measure, whether the Contractor satisfied the goal established by the Department, and whether the Contractor shall be required to implement a performance improvement initiative. The Contractor shall have sixty (60) days to review and respond to the Department's performance report.

The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractors submitted encounter data. The Contractor shall have 60 days to review and respond to findings reported as a result of these activities.

The Department further reserves the right to implement and require different quality measures. The Contractor shall be given no less than ninety (90) days to comply with any new quality measurement requirement.

20.3 Accreditation of Contractor by National Accrediting Body

If the Contractor holds a current NCQA accreditation status it shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Review Tool (IRT): Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department. All submissions shall include a copy to the Department's Division of Program Quality & Outcomes, Managed Care Oversight Quality Branch Manager. The Contractor shall authorize the accrediting entity to provide the Department a copy of its most recent accreditation review, including:

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A. Accreditation status, survey type, and level (as applicable);
B. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
C. Expiration date of the accreditation.

If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the **Contractor** shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of its initial MCO Contract with the Commonwealth.

20.4 Performance Improvement Projects (PIPs)

Performance Improvement Projects (PIPs) are intended to address and achieve significant (demonstrable) and sustained improvement in focus areas over time. The projects are designed to measure diverse aspects of care, and care provided to diverse populations of Enrollees. The Contractor must ensure that the chosen topic areas for PIP's are not limited to only recurring, easily measured subsets of the health care needs of its Enrollees. The selected PIPs topics must consider: the prevalence of a condition in the enrolled population; the need(s) for a specific service(s); Enrollee demographic characteristics and health risks; and the interest of Enrollees in the aspect of care/services to be addressed.

The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Enrollees, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and Enrollee satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to an Enrollee. Clinical PIPs should address preventive and chronic healthcare needs of Enrollees, including the Enrollee population as a whole and subpopulations, including, but not limited to Medicaid eligibility category, type of disability or special healthcare need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs of Enrollees with conditions and illnesses that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability, and accessibility of services provided by the Contractor to Enrollees and Providers. Such aspects of service should include, but not be limited to availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.

The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies, community based health/social agencies and health care delivery systems to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives. The Contractor shall be committed to ongoing collaboration in the area of service and clinical care improvements by the development of best practices, use of encounter data–driven performance measures and establishment of relationship with existing organizations engaged in provider performance improvement through education and training in best practices and data collection. Evidence of adequate partnerships should include formal documentation of meetings, input from stakeholders and shared responsibility in the design and implementation of PIP activities.

The Department recognizes that the following conditions are prevalent in the Medicaid population in the Commonwealth and recommends that the Contractor considers the following topics for PIPs: diabetes, coronary artery disease screenings, colon cancer screenings, cervical cancer screenings, behavioral health, reduction in ED usage and management of ED Services. However, the Contractor may propose an alternative topic(s) for its PIPs to meet the unique needs of its Enrollees if the proposal and justification for the alternative(s) are submitted to and

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approved by the Department.

Additionally, the Department shall require the Contractor to implement an additional PIP specific to the Contractor, if findings from an EQR review or audit indicate the need for a PIP, or if directed by CMS. The Contractor shall assist the Department by supplying readily available data, soliciting input and supporting clinicians. The Contractor shall submit reports on PIPs as specified by the Department.

The Contractor shall report on each PIP utilizing the template provided by the Department and shall address all of the following in order for the Department to evaluate the reliability and validity of the data and the conclusions drawn:

A. Topic and its importance to Enrollees;
B. Methodology for topic selection;
C. Goals;
D. Data sources/collection;
E. Intervention(s) – not required for projects to establish baseline; and
F. Results and interpretations – clearly state whether performance goals were met, and if not met, analysis of the intervention and a plan for future action.

The final report shall also answer the following questions and provide information on:

A. Was Enrollee confidentiality protected;
B. Did Enrollees participate in the performance improvement project;
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;
D. How financial impact might determine sustainability of improvement achieved;
E. Were the results and conclusions made available to Enrollees, providers and any other interested bodies;
F. Is there an executive summary;
G. How could findings be reported to a broad audience of relevant stakeholders or the general public; and
H. Do illustrations – graphs, figures, tables – convey information clearly.

Performance reporting shall utilize standardized indicators appropriate to the performance improvement area. Minimum performance levels shall be specified for each performance improvement area, using standards derived from regional or national norms or from norms established by an appropriate practice organization. The norms and/or goals shall be pre-determined at the commencement of each performance improvement goal and the Contractor shall be monitored for achievement of demonstrable and/or sustained improvement.

The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement. The timeframes for reporting:

A. Project Proposal including baseline measurement – due September 1 of Contract year. Proposal with baseline measurement is required upon submission of completed PIP. If PIP identified as a result of Department/EQRO review, the project proposal shall be due sixty (60) days after notification of requirement.
B. 1st Remeasurement – no more than one calendar year after baseline measurement and no later than September 1 of the Contract year following baseline measurement.
C. Conclusion – no more than one calendar year after the first remeasurement and no later than September 1 of the Contract year when the PIP concludes.

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No new PIPs will be required by the Department for SFY 2020.

20.5 Quality and Member Access Committee

The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Enrollees, individuals from consumer advocacy groups or the community who represent the interests of the Enrollee population.

Enrollees of the committee shall be consistent with the composition of the Enrollee population, including such factors as aid category, gender, geographic distribution, parents, as well as adult Enrollees and representation of racial and ethnic minority groups. Enrollee participation may be excused by the Department upon a showing by Contractor of good faith efforts to obtain Enrollee participation. Responsibilities of the committee shall include:

A. Meeting at least quarterly;
B. Providing review and comment on quality and access standards;
C. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data;
D. Proving review and comment on Enrollee Handbooks;
E. Reviewing Enrollee education materials prepared by the Contractor;
F. Recommending community outreach activities; and
G. Providing reviews of and comments on Contractor and Department policies that affect Enrollees.

The list of the Enrollees participating with the QMAC shall be submitted to the Department annually.

21.0 Utilization Management

21.1 Medical Necessity

The Utilization Management (UM) program, processes and timeframes shall be in accordance with 42 C.F.R. 456, 42 C.F.R. 431, 42 C.F.R. 438 and the private review agent requirements of KRS 304.17A as applicable. The Contractor shall have a comprehensive UM program that reviews services for Medical Necessity and clinical appropriateness, and that monitors and evaluates on an ongoing basis the appropriateness of care and services for physical and behavioral health. A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities. The description shall include the scope of the program; the processes and information sources used to determine service coverage; clinical necessity, appropriateness and effectiveness; policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery; processes to review, approve and deny services, as needed, particularly but not limited to the EPSDT program. The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes. The UM program evaluation along with any changes to the UM program as a result of the evaluation findings, will be reviewed and approved annually by the Medical Director, the Behavioral Health Director, or the Department.

21.2 National Standards for Medical Necessity Review

The Contractor shall adopt Interqual for Medical Necessity except that the Contractor shall utilize the American Society of Addiction Medicine (ASAM) for substance use. If Interqual does not cover a behavioral health service, the Contractor shall adopt the following standardized tools for

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medical necessity determinations -- for adults: Level of Care Utilization System (LOCUS); for children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children; Early Childhood Service Intensity Instrument (ECSII).

If it is determined that one of the medical necessity criteria named in this section is not available or not specifically addressed for a service or for a particular population, the Contractor shall submit its proposed medical necessity criteria to the Department for approval subject to Section 4.4 "**Approval of Department**". The Department may also, at its discretion, require the use of other criteria it creates or identifies for services or populations not otherwise covered by the named criteria in the above paragraph. The Contractor will be given ninety (90) days to implement criteria the Department may otherwise require.

The Contractor shall have in place mechanisms to check the consistency of application of review criteria. The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate. The Medical Director and Behavioral Health Director shall supervise the UM program and shall be accessible and available for consultation as needed. Criteria approved under a prior contract must be resubmitted to ensure it meets the requirements of this Contract.

Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a physician who has appropriate clinical expertise in treating the Enrollee's condition or disease. The clinical reason for the denial, in whole or in part, specific to the Enrollee shall be cited. Physician consultants from appropriate medical, surgical and psychiatric specialties shall be accessible and available for consultation as needed. The Medical Necessity review process shall be completed within two (2) business days of receiving the request and shall include a provision for expedited reviews in urgent decisions. Post-service review requests shall be completed within fourteen (14) days or, if the Enrollee or the Provider requests an extension or the Contractor justifies a need for additional information and how the extension is in the Enrollee's interest, may extend up to an additional fourteen (14) days.

A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.
B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.
C. In the event that an Enrollee or Provider requests written confirmation of an approval, the Contractor shall provide written confirmation of its decision within three working days of providing notification of a decision if the initial decision was not in writing. The written confirmation shall be written in accordance with Enrollee Rights and Responsibilities.
D. The Contractor shall have written policies and procedures that show how the Contractor shall monitor to ensure clinically appropriate overall continuity of care.
E. The Contractor shall have written policies to ensure the coordination of services:
    1. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;
    2. With the services the Enrollee receives from any other MCO;
    3. With the services the Enrollee receives in FFS; and
    4. With the services the Enrollee receives from community and social support providers.
F. The Contractor shall have written policies and procedures that explain how prior authorization data shall be incorporated into the Contractor's overall Quality Improvement Plan.

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Each subcontract must provide that, consistent with 42 C.F.R. Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to an Enrollee.

The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services. The written program description shall address the procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes and the process used to review and approve the provision of medical services. The Contractor shall evaluate Enrollee satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys. The UM program will be evaluated by the Department on an annual basis.

21.3 Adverse Benefit Determination Related to Requests for Services and Coverage Denials

The Contractor shall provide the Enrollee written notice that meets the language and formatting requirements for Enrollee materials, of any adverse benefit determination (not just service authorization actions) within the timeframes for each type of adverse benefit determination pursuant to 42 C.F.R. 438.210(d) and in compliance with 42 C.F.R. 438.404 and other provisions of this Contract. The notice must explain:

A. The adverse benefit determination the Contractor has made or intends to make;
B. The reasons for the adverse benefit determination in clear, non–technical language that is understandable by a layperson;
C. The right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee's adverse benefit determination, including medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;
D. Specific and detailed information as to why the service did not meet medical necessity, if the action related to a denial, in whole or in part, of a service is due to a lack of medical necessity;
E. The federal or state regulation supporting the action, if applicable;
F. The Enrollee's right to appeal including information on exhausting the Contractor's one level of appeal as required by 42 C.F.R. 438.402(b);
G. The Enrollee's right to request a State Fair Hearing after receiving notice that the adverse benefit determination is upheld;
H. Procedures for exercising Enrollee's rights to Appeal or file a Grievance;
I. Circumstances under which the appeal process can be expedited and how to request it;
J. The Enrollee's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Enrollee may be required to pay the costs of these services;
K. Be available in English, Spanish, and each prevalent non-English language;
L. Be available in alternative formats for persons with special needs; and
M. Be easily understood in language and format.

The Contractor shall give notice at least:

A. Ten (10) Days before the date of an adverse benefit determination when the adverse benefit determination is a termination, suspension or reduction of a covered service authorized by the Department, its agent or Contractor, except the period of advanced notice is shortened to five (5) Days if Enrollee Fraud or Abuse has been determined.
B. The Contractor shall give notice by the date of the adverse benefit determination for the following:
    1. In the death of an Enrollee;

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2. A signed written Enrollee statement requesting service termination or giving information requiring termination or reduction of services (where he or she understands that this will be the result of supplying that information);
3. The Enrollee's admission to an institution where he or she is ineligible for further services;
4. The Enrollee's address is unknown and mail directed to him or her has no forwarding address;
5. The Enrollee has been accepted for Medicaid services by another local jurisdiction;
6. The Enrollee's physician prescribes the change in the level of medical care;
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;
8. The safety or health of individuals in the facility would be endangered, the Enrollee's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Enrollee's urgent medical needs, or an Enrollee has not resided in the nursing facility for thirty (30) days.

C. The Contractor shall give notice on the date of the adverse benefit determination when the adverse benefit determination is a denial of payment.

D. The Contractor shall give notice as expeditiously as the Enrollee's health condition requires and within State-established timeframes that may not exceed two (2) business days following receipt of the request for service, with a possible extension of up to fourteen (14) additional days, if the Enrollee or the Provider requests an extension, or the Contractor justifies a need for additional information and how the extension is in the Enrollee's interest. If the Contractor extends the timeframe for an appeal or expedited appeal, and the extension was not at the request of the Enrollee, the Contractor must make reasonable efforts to give the Enrollee prompt oral notice of the delay; give the Enrollee written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and resolve the appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than two (2) business days after receipt of the request for service.

F. The Contractor shall give notice on the date that the time frames expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and is thus an adverse benefit determination.

21.4 Prior Authorizations

The Department shall provide a common Prior Authorization Form for all Contractors to utilize for a Provider to initiate the prior authorization process. The Contractor shall give the Provider the option to use the common form or the Contractor specific form. The Contractor's prior authorization process shall comply with provisions of this Contract.

The Contractor shall approve or deny a standard Prior Authorization request within two (2) business days. The timeframe for a standard authorization request may be extended up to fourteen (14) days if the Provider or Enrollee requests an extension, or if the Contractor justifies, in writing, to the Department a need for additional information and how the extension is in the Enrollee's best interest.

The Contractor shall make Prior Authorization determinations in a timely and consistent manner so that Enrollees with comparable medical needs receive comparable and consistent levels, amounts, and duration of services as supported by the Enrollee's medical condition, records, and

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previous affirmative coverage decisions.

21.5 Assessment of Enrollee and Provider Satisfaction and Access

The Contractor shall conduct an annual survey of Enrollees' and Providers' satisfaction with the quality of services provided and their degree of access to services. The Enrollee satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children with a separate sample and survey for CHIP Enrollees, administered by an NCQA certified survey vendor. The Contractor shall provide a copy of the current CAHPS survey tool to the Department. Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services. To meet the provider satisfaction survey requirement, the Contractor shall submit to the Department for review and approval the Contractor's provider satisfaction survey tool. The Department shall review and approve any Enrollee and Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used conducting the Provider or other special surveys, the number and percentage of the Providers or Enrollees to be surveyed, response rates, and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned. All survey results must be reported to the Department, and upon request, disclosed to Enrollees.

22.0 Monitoring and Evaluation

22.1 Financial Performance Measures

Contractor shall provide reports quarterly on trends in utilization for each category of eligibility in a format as directed by the Department. These categories of eligibility trends should include but not necessarily be limited to:

A. inpatient hospital admissions and days per thousand Enrollee months;
B. outpatient hospital visits per thousand Enrollee month;
C. emergency room visits per thousand Enrollee months;
D. percent of emergency room visits resulting in admission;
E. ambulatory surgery / procedures per thousand Enrollee months; hospital readmissions within 30 days per thousand Enrollee months;
F. average visits per provider by major provider type;
G. PRTF admits and days per thousand;
H. mental hospital admits and days per thousand;
I. prescriptions dispensed by major drug class per thousand Enrollee months;
J. Pharmacy cost PMPM.

In addition, a report shall be provided that displays expenditures by category of service by both month of service and month of payment; this report should distinguish between the eight major categories of eligibility: 1) Families and Children – Child, 2) Families and Children – Adult, 3) SSI without Medicare Adult, 4) SSI Child and 5) Foster Care Child, 6) Dual Eligibles, 7) ACA MAGI Adults, and 8) ACA Former Foster Care Child.

22.2 Monitoring Requirements

The Contractor is responsible for the faithful performance of the Contract and shall have internal monitoring procedures and processes in place to ensure compliance. The Contractor is responsible for oversight of its subcontract(s) and shall have internal monitoring procedures and

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processes in place to ensure compliance. The Contractor shall ensure that all subcontractor(s) work for the purpose of fulfilling a Contractor's obligation under this contract. The Contractor shall fully cooperate with the Department, its agent and/or Contractor in the Contract monitoring, which includes but is not limited to: tracking and/or auditing activity, which may require the Contractor to report progress and problems, provide documents, allow random inspections of its facilities, participate in scheduled meetings and monitoring, respond to requests for corrective action plans and provide reports as requested by the Department. Cooperation in Contract monitoring and provision of documents during Contract monitoring shall be at no additional cost to the Department.

22.3 External Quality Review

Section 1902(a)(30)(c) of Title XIX of the Social Security Act, requires the Commonwealth to acquire an independent external review body for the purpose of performing an annual review of the quality of services provided by an MCO under contract with the Commonwealth, including the evaluation of quality outcomes and timeliness of access to services. Requirements relating to the External Quality Review (EQR) are further defined and described under 42 C.F.R. 438, Subpart E. The results of EQR are made available, upon request, to specified groups and to interested stakeholders. The Contractor shall provide information to the External Quality Review Organization EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 C.F.R. Part 438.

The Contractor shall cooperate and participate in EQR activities in accordance with protocols identified under 42 C.F.R. 438, Subpart E. These protocols guide the independent external review of quality outcomes and timeliness of and access to services provided by a Contractor providing Medicaid services.

In an effort to avoid duplication, the Department may also use, in place of such audit, information obtained about the Contractor from a Medicare or private accreditation review in accordance with 42 C.F.R. 438.360.

22.4 EQR Administrative Reviews

The Contractor shall assist the EQRO in completing all Contractor reviews and evaluations in accordance with established protocols previously described. The Contractor shall assist the Department and the EQRO in identification of Provider and Enrollee information required to carry out annual, external independent reviews of the quality outcomes, and timeliness of on-site or off-site medical chart reviews. Timely notification of Providers and subcontractors of any necessary medical chart review shall be the responsibility of the Contractor.

22.5 EQR Performance

If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO. The Contractor shall:

A. Assign a staff person(s) to conduct follow-up concerning review findings;
B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan;
C. Submit a corrective action plan in writing to the EQRO and Department within 10 business days that addresses the measures the Contractor intends to take to resolve the finding. The Contractor's final resolution of all potential quality concerns shall be completed within six (6) months of the Contractor's notification. An extension to submit may be extended in

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accordance with Section 40.4.D;

D. The Contractor shall demonstrate how the results of the External Quality Review (EQR) are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate progressive and measurable improvement during the term of this Contract; and
E. If Contractor disagrees with the EQRO's findings, it shall submit its position to the Commissioner of the Department whose decision is final.

23.0 Enrollee Services

23.1 Required Functions

The Contractor shall have an Enrollee Services function that includes a call center which is staffed and available by telephone Monday through Friday 7 am to 7 pm Eastern Time (ET). The call center shall meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer for all Contractor programs with the exception of behavioral health which is addressed in Section 34.6.

If a Contractor has separate telephone lines for different Medicaid populations, the Contractor shall report performance for each individual line separately.

The Contractor shall also provide access to medical advice and direction through a centralized toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week nationwide. The twenty-four/seven (24/7) call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses, and registered nurses.

The Contractor shall self-report their prior month performance in the three areas listed above, call center abandonment rate, blockage rate and average speed of answer, for their Enrollee services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.

Appropriate foreign language and/or oral interpreters shall be provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education and otherwise comply with 42 C.F.R. 438.10(d). Enrollee written materials shall be provided and printed in English, Spanish, and each prevalent non-English language. Oral interpretation shall be provided for all non-English languages. The Contractor staff shall be able to respond to the special communication needs of the disabled, blind, deaf, and aged, and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.

The Contractor shall require that all Service Locations meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to an Enrollee's records when written Enrollee consent is provided.

The Contractor's Enrollee Services function shall also be responsible for:

A. Ensuring that Enrollees are informed of their rights and responsibilities;
B. Ensuring each Enrollee is free to exercise his or her rights without the Contractor or its Providers treating the Enrollee adversely.

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C. Guaranteeing each Enrollee's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand.
D. Monitoring the selection and assignment process of PCPs;
E. Identifying, investigating, and resolving Enrollee Grievances about health care services;
F. Assisting Enrollees with filing formal Appeals regarding plan determinations;
G. Providing each Enrollee with an identification card that identifies the Enrollee as a participant with the Contractor, unless otherwise approved by the Department;
H. Explaining rights and responsibilities to Enrollees or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;
I. Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled Enrollee office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;
J. Providing within five (5) business days of the Contractor being notified of the enrollment of a new Enrollee, by a method that will not take more than three (3) days to reach the Enrollee, and whenever requested by the Enrollee, guardian or authorized representative, an Enrollee Handbook and information on how to access services; (alternate notification methods shall be available for persons who have reading difficulties or visual impairments);
K. Explaining or answering any questions regarding the Enrollee Handbook;
L. Facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The Contractor shall assist Enrollees to make the most appropriate Primary Care Provider selection based on previous or current Primary Care Provider relationship, providers of other family Enrollees, medical history, language needs, provider location and other factors that are important to the Enrollee. The Contractor shall notify Enrollees within thirty (30) days prior to the effective date of voluntary termination (or if Provider notifies Contractor less than thirty (30) days prior to the effective date, as soon as Contractor receives notice), and within fifteen (15) days prior to the effective date of involuntary termination if their Primary Care Provider leaves the Program and assist Enrollees in selecting a new Primary Care Provider;
M. Facilitating direct access to specialized providers in the circumstances of:
    1. Enrollees with long-term, complex health conditions;
    2. Aged, blind, deaf, or disabled persons; and
    3. Enrollees who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through referrals from the Primary Care Provider or by the specialty physician being permitted to serve as the Primary Care Provider.
N. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;
O. Providing Enrollees with information or referring to support services offered outside the Contractor's Network such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse;
P. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Enrollees under age 18; childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases; all as further described in Appendix H. "Covered Services" of this Contract;
Q. Facilitating access to behavioral health services and pharmaceutical services;
R. Facilitating access to the services of public health departments, Community Mental Health Centers, rural health clinics, Federally Qualified Health Centers, the Commission for Children with Special Health Care Needs and charitable care providers, such as Shriner's Hospital for Children;
S. Assisting Enrollees in making appointments with Providers and obtaining services. When the Contractor is unable to meet the accessibility standards for access to Primary Care

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Providers or referrals to specialty providers, the Enrollee Services staff function shall document and refer such problems to the designated Enrollee Services Director for resolution;

T. Assisting Enrollees in obtaining transportation for both emergency and appropriate non-emergency situations;
U. Handling, recording and tracking Enrollee Grievances properly and timely and acting as an advocate to assure Enrollees receive adequate representation when seeking an expedited Appeal;
V. Facilitating access to Enrollee Health Education Programs;
W. Assisting Enrollees in completing the Health Risk Assessment (HRA) as outlined in Appendix H. "Covered Services" upon any telephone contact; and referring Enrollees to the appropriate areas to learn how to access the health education and prevention opportunities available to them including referral to case management or disease management; and
X. The Enrollee Services staff shall be responsible for making an annual report to management about any changes needed in Enrollee services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department.

23.2 Enrollee Handbook

The Contractor shall publish an Enrollee Handbook and make the handbook available to Enrollees upon enrollment, to be delivered to the Enrollee within five (5) business days of Contractor's notification of Enrollee's enrollment. With the exception of a new Enrollee assigned to the Contractor, the Contractor is in compliance with this requirement if the Enrollee's handbook is:

A. Mailed within five (5) business days by a method that will not take more than three (3) days to reach the Enrollee;
B. Provided by email after obtaining the Enrollee's agreement to receive the information by email;
C. Posted on the Contractor's website and the Contractor advises the Enrollee in paper or electronic form that the information is available on the internet and includes the internet address, provided that Enrollee's with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
D. Provided by any other method that can reasonably be expected to result in the Enrollee receiving that information.

For any new Enrollee assigned to the Contractor, the Contractor shall mail a hard copy of the Enrollee Handbook within five (5) business days of notification of the assignment.

If the information is provided electronically, it must be in a format that is readily accessible, is placed in a location on the website that is prominent and easily accessible, can be electronically retained and printed, and that the information is available in paper form without charge upon request within five (5) business days.

The Enrollee Handbook shall be available in English, Spanish, and each prevalent non-English language. The Enrollee Handbook shall be available in a hardcopy format as well as an electronic format online. The Contractor shall review the handbook at least annually and shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers, covered services and any service not covered by the Contractor because of moral or religious objections. Contractor shall communicate any changes to Enrollees in written form as least thirty (30) days before the intended effective date of the change. Revision dates shall be added to the Enrollee Handbook so that it is evident which version is the most current. Changes shall be approved by the Department prior to printing. The Department has the authority to review the Contractor's Enrollee Handbook at any time.

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Pursuant to 42 C.F.R. 438.10, the Department may develop and require the use of a model handbook and/or notices. The Contractor shall be given at least sixty (60) days to implement any model handbook or change any notice.

The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:

A. The Contractor's Network of Primary Care Providers, including a list of the names, telephone numbers, and service site addresses of PCPs available for Primary Care Providers in the network listing. The network listing may be combined with the Enrollee Handbook or distributed as a stand-alone document;
B. How to access a list of network providers for covered services in paper form, upon request, or electronic form containing information required in 42 C.F.R. 438.10(h);
C. Any restrictions on an Enrollee's freedom of choice among network providers;
D. The procedures for selecting a PCP and scheduling an initial health appointment or requesting a change of PCP and specialists; reasons for which a request may be denied; and reasons a Provider may request a change;
E. The availability of oral interpretation services for all languages, written translations in English, Spanish, and each prevalent non-English language as well as for the top 15 non-English languages as released by the U.S. Department of Health and Human Services, Office for Civil Rights, alternative formats, and other auxiliary aids and services as well as how to access those services;
F. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and the Enrollee Services telephone number and twenty-four/seven (24/7) toll-free medical call-in system;
G. A list of all available Covered Services, an explanation of any service limitations or exclusions from coverage, including those due to moral or religious objections, and a notice stating that the Contractor shall be liable only for those services authorized by the Contractor;
H. Enrollee rights and responsibilities including reporting suspected fraud and abuse and the elements specified in 42 C.F.R. 438.100;
I. Procedures for obtaining Emergency Care and non-emergency care after hours, what constitutes an emergency medical condition, the fact that a prior authorization is not required for emergency services and the right to use any hospital or other setting for emergency care. For a life-threatening situation, instruct Enrollees to use the emergency medical services available or to activate emergency medical services by dialing 911;
J. Procedures for obtaining transportation for both emergency and non-emergency situations;
K. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;
L. Procedures for arranging EPSDT for persons under the age of twenty-one (21) years;
M. Procedures for obtaining access to Long Term Care Services;
N. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;
O. A list of direct access services that may be accessed without the authorization of a PCP;
P. Information about how to access care before a PCP is assigned or chosen;
Q. An Enrollee's right to obtain a second opinion in or out of the Contractor's Provider network and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;
R. Procedures for obtaining Covered Services from non-network providers;
S. Procedures and timelines for filing a Grievance or Appeal. This shall include the title, address and telephone number of the person responsible for processing and resolving Grievances and Appeals, the availability of assistance in the filing process, the right of the Enrollee to a State Fair Hearing and that benefits will continue while under appeal if MCO decision is to reduce or terminate services;
T. Information about the Cabinet for Health and Family Services' independent ombudsman

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program for Enrollees;

U. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;
V. Information on the availability of health education services
W. Any cost sharing imposed;
X. How to exercise an advance directive;
Y. Information deemed mandatory by the Department; and
Z. The availability of care coordination case management and disease management provided by the Contractor.

23.3 Enrollee Education and Outreach

The Contractor shall develop, administer, implement, monitor and evaluate an Enrollee and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to its Enrollees. The Outreach Program shall encourage Enrollees and community partners to use the information provided to best utilize services and benefits.

Creative methods should be used to reach Contractor's Enrollees and community partners. These must include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites.

The Contractor shall submit an annual outreach plan to the Department for review and approval subject to Section 4.4 "**Approval of Department**." The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.

23.4 Outreach to Homeless Persons

The Contractor shall assess the homeless population by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence. The plan shall include:

A. Utilizing existing community resources such as shelters and clinics; and
B. Face-to-face encounters.

The Contractor shall not differentiate services for Enrollees who are homeless. Victims of domestic violence should be a target for outreach as they are frequently homeless. Assistance with transportation to access health care may be provided via bus tokens, taxi vouchers or other arrangements when applicable.

23.5 Enrollee Information Materials

All written materials provided to Enrollees that are critical to obtaining services, including, at a minimum, marketing materials, new Enrollee information, provider directories, handbooks, denial and termination notices, and grievance and appeal information shall comply with 42 C.F.R. 438.10(d) and 45 C.F.R. 92 unless otherwise specifically addressed in this Contract. The information shall at a minimum:

A. Be geared toward persons who read at a sixth-grade level and use easily understood language and format;
B. Be published in at least a twelve (12) point font size, and available in large print in a font size

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no smaller than 18 point, except font size requirements shall not apply to Enrollee Identification Cards;

C. Comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).
D. Be available through auxiliary aids and services, upon request of the Enrollee at no cost;
E. Be available in alternative formats, upon request of the Enrollee at no cost;
F. Be available in English, Spanish, and each prevalent non-English language;
G. Be provided through oral interpretation services for any language;
H. Include taglines in the top 15 non-English languages as released by the U.S. Department of Health and Human Services Office of Civil Rights, as well as large print, explaining the availability of written translation or oral interpretation and the toll-free telephone number of the Contractor's entity providing those services and how to request services.

All written materials provided to Enrollees, including forms used to notify Enrollees of Contractor actions and decisions, with the exception of written materials unique to individual Enrollees, unless otherwise required by the Department shall be submitted to the Department for review and, approval prior to publication and distribution to Enrollees such approval by the Department shall be subject to Section 4.4 "**Approval of Department**."

23.6 Information Materials Requirements

The Contractor shall notify all Enrollees of their right to request and obtain the information listed herein at least once a year and within a reasonable time after the Contractor receives from the Department notice of the Enrollee's enrollment. Any change in the information listed herein shall be communicated at least thirty (30) days before the intended effective date of the change.

A. Names, locations, telephone numbers of, and non-English languages spoken by, Providers in the Contractor's network, including identification of Providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
B. Any restrictions on the Enrollee's freedom of choice among network Providers.
C. Any changes in covered services by the Contractor due to moral or religious objections and how to obtain the service.
D. Enrollee rights and protections, as specified in 42 C.F.R. §438.100.
E. Information on the right to file grievances and appeals and procedures as provided in 42 C.F.R. §§438.400 through 438.424 and 907 KAR 17:010, including: requirements and timeframes for filing a grievance or appeal; availability of assistance in the filing process; toll-free numbers that the Enrollee can use to file a grievance or an appeal by phone; that when requested benefits can continue during the grievance or appeal; and that the Enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Enrollee.
F. Information on a State fair hearing including the right to hearing; method for obtaining a hearing; and rules that govern representation at the hearing.
G. The amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled.
H. Procedures for obtaining benefits, including authorization requirements.
I. The extent to which, and how, Enrollees may obtain benefits, including family planning services, from out-of-network providers.
J. The extent to which, and how, after-hours and emergency coverage are provided, including:
    1. What constitutes emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in 42 C.F.R. §438.114(a) and 907 KAR 3:130.
    2. The fact that prior authorization is not required for emergency services.
    3. The process and procedures for obtaining emergency services, including use of the 911-telephone system.
    4. The locations of any emergency settings and other locations at which providers and

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hospitals furnish emergency services and post-stabilization services covered under the Contract.

5. The fact that, subject to the provisions of this section, the Enrollee has a right to use any hospital or other setting for emergency care.

K. The post-stabilization care services rules set forth at 42 C.F.R. §422.113(c).
L. The Contractor's policy on referrals for specialty care and for other benefits not furnished by the Enrollee's primary care provider.
M. Cost sharing, if any.
N. How and where to access any benefits that are available under the State plan but are not covered under the Contract.
O. Any appeal rights made available to Providers to challenge the failure of the Contractor to cover a service.
P. Advance directives, as set forth in 42 C.F.R. §438.6(i)(2).
Q. Upon request, information on the structure and operation of the Contractor and physician incentive plans.
R. An Enrollee's right to request and receive a copy of his or her medical records and request that the records be amended or corrected.

23.7 Enrollee Rights and Responsibilities

The Contractor shall have written policies and procedures that are in compliance with Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972; Titles II and III of the Americans with Disabilities Act; Section 1557 of the ACA and 42 C.F.R. 438.100, and designed to protect the rights of Enrollees and enumerate the responsibilities of each Enrollee. A written description of the rights and responsibilities of Enrollees shall be included in the Enrollee information materials provided to new Enrollees. A copy of these policies and procedures shall be provided to all of the Contractor's Network Providers to whom Enrollees may be referred. In addition, these policies and procedures shall be provided to any Out-of-Network Provider upon request from the Provider.

The Contractor's written policies and procedures that are designed to protect the rights of Enrollees, in accordance with federal and state law, shall include, without limitation, the right to:

A. Respect, dignity, privacy, confidentiality, accessibility and nondiscrimination;
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;
C. Consent for or refusal of treatment and active participation in decision choices;
D. Ask questions and receive complete information relating to the Enrollee's medical condition and treatment options, including specialty care;
E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and request a state fair hearing from the Contractor and/or the Department;
F. Timely access to care that does not have any communication or physical access barriers;
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;
H. Assistance with medical records in accordance with applicable federal and state laws;
I. Timely referral and access to medically indicated specialty care; and
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
K. Receive information in accordance with 42 C.F.R. 438.10;
L. Be furnished health care services in accordance with 42 C.F.R. Part 438;
M. Any Indian enrolled with the Contractor eligible to receive services from a participating I/T/U provider or a I/T/U primary care provider shall be allowed to receive services from that provider if part of Contractor's network,

The Contractor shall also have policies addressing the responsibility of each Enrollee to:

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A. Become informed about Enrollee rights;
B. Abide by the Contractor's and Department's policies and procedures;
C. Become informed about service and treatment options;
D. Actively participate in personal health and care decisions, practice healthy lifestyles;
E. Report suspected Fraud and Abuse; and
F. Keep appointments or call to cancel.

23.8 Enrollee Choice of MCO

The Department will enroll and disenroll eligible Enrollees in conformance with this Contract. The Contractor is not allowed to induce or accept disenrollment from an Enrollee. The Contractor shall direct the Enrollee to contact the Department for enrollment or disenrollment questions.

The Department makes no guarantees or representations to the Contractor regarding the number of eligible Enrollees who may ultimately be enrolled with the Contractor or the length of time any Enrollee may remain enrolled with the Contractor.

The Department will electronically transmit to the Contractor new Enrollee information monthly and will electronically transmit demographic changes regarding Enrollees daily.

23.9 Identification Cards

The Contractor shall issue an identification card for every Enrollee assigned to it. The Identification card will also include the PCP, if applicable, and the Enrollee's Identification Number.

24.0 Enrollee Selection of Primary Care Provider (PCP)

24.1 Enrollees Not Required to Have a PCP

Dual Eligible Enrollees and Enrollees who are presumptively eligible are not required to have a Primary Care Provider (PCP).

A PCP shall be required for adults for whom the state is appointed guardian, disabled children, and foster care children effective October 1, 2019.

24.2 Enrollee Choice of Primary Care Provider

Enrollees shall choose or have the Contractor select a PCP for their medical home. The Contractor shall have two processes in place for Enrollees to choose a PCP:

A. A process for Enrollees who have SSI coverage but are not Dual Eligible Enrollees; and
B. A process for other Enrollees.

24.3 Enrollees without SSI

An Enrollee without SSI shall be offered an opportunity to: (1) choose a new PCP who is affiliated with the Contractor's network or (2) stay with their current PCP as long as such PCP is affiliated with the Contractor's network. Each Enrollee shall be allowed to choose his or her Primary Care Provider from among all available Contractor Network Primary Care Providers and specialists as is reasonable and appropriate for Enrollee.

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The Contractor shall have procedures for serving Enrollees from the date of notification of enrollment, whether or not the Enrollee has selected a Primary Care Provider. The Contractor shall send Enrollees a written explanation of the Primary Care Provider selection process within ten (10) business days of receiving enrollment notification from the Department, either as a part of the Enrollee Handbook or by separate mailing. Enrollees will be asked to select a Primary Care Provider by contacting the Contractor's Enrollee Services department with their selection. The written communication shall include the timeframe for selection of a Primary Care Provider, an explanation of the process for assignment of a Primary Care Provider if the Enrollee does not select a Primary Care Provider and information on where to call for assistance with the selection process.

An Enrollee shall be allowed to select, from all available, but not less than two (2) Primary Care Providers in the Contractor's Network.

Contractor shall assign the Enrollee to a Primary Care Provider:

A. Who has historically provided services to the Enrollee, meets the Primary Care Provider criteria and participates in the Contractor's Network;
B. If there is no such Primary Care Provider who has historically provided services, the Contractor shall assign the Enrollee to a Primary Care Provider, who participates in the Contractor's Network and is within thirty (30) miles or thirty (30) minutes from the Enrollee's residence in an urban area or within forty-five (45) miles or forty-five (45) minutes from the Enrollee's residence in a rural area. The assignment shall be based on the following:
    1. The need of children and adolescents to be followed by pediatric or adolescent specialists;
    2. Any special medical needs, including pregnancy;
    3. Any language needs made known to the Contractor; and
    4. Area of residence and access to transportation.

The Contractor shall monitor and document in a quarterly report to the Department the number of eligible individuals that are assigned a PCP. The Contractor shall notify the Enrollee, in writing, of the PCP assignment, including the Provider's name, and office telephone number. The Contractor shall make available to the PCP a roster on the first day of each month of Enrollees who have selected or been assigned to his/her care.

If the Contractor assigns the Enrollee a PCP prior to offering the Enrollee the process above for self-selection, then in the event the Contractor receives a request from the Enrollee within thirty (30) days for a reassignment, the reassignment shall be retroactively effective to the date of the Enrollee's assignment to the Contractor.

24.4 Enrollees who have SSI and Non-Dual Eligibles

An Enrollee who has SSI but is not a dual eligible shall be offered an opportunity to: (1) choose a new PCP who is affiliated with the Contractor's network or (2) stay with their current PCP as long as such PCP is affiliated with the Contractor's network. Each Enrollee shall be allowed to choose his or her Primary Care Provider from among all available Contractor Network Primary Care Providers and specialists as is reasonable and appropriate for Enrollee.

The Contractor shall send Enrollees information regarding the requirement to select a PCP, or one will be assigned to them according to the following:

A. Upon Enrollment, the Enrollee shall receive a letter requesting them to select a PCP. This letter may be included in the Enrollee Welcome Kit. After thirty (30) days, if the Enrollee has not selected a PCP, the Contractor shall send a second letter requesting the Enrollee to

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select a PCP. If the Enrollee does not select a PCP within thirty (30) days of the second notice, the Contractor shall send a third notice to the Enrollee.

B. At the end of the third thirty (30) day period, if the Enrollee has not selected a PCP, the Contractor shall select a PCP for the Enrollee and send a card identifying the PCP selected for the Enrollee and informing the Enrollee specifically that the Enrollee can contact the Contractor and make a PCP change.

If the Contractor assigns the Enrollee a PCP prior to offering the Enrollee the process above for self-selection, then in the event the Contractor receives a request from the Enrollee for a PCP reassignment within thirty (30) days of the auto assignment, the reassignment shall be retroactively effective to the date of the Enrollee's assignment to the Contractor.

24.5 Selection Procedures for Foster Children, Adoption and Guardianship

DCBS and DAIL staff are authorized to apply for Medicaid on behalf of foster children (DCBS) and guardianship clients (DAIL) through an expedited application process agreed on by the Department and DCBS and DAIL.

Enrollees who are children in foster care and adult guardianship clients may move frequently from one placement to another. The parties agree that the following procedures will be used to determine the residence of these Enrollees for the purpose of maintaining -a PCP selection.

Foster Children. For Enrollees who are in foster care, assignment will be based on where the foster child's DCBS case is located (which is usually the Medicaid Region where the child's family of origin resides). It is the responsibility of the DCBS to notify the Contractor of a foster child's change in placement.

Adopted Children. For Enrollees who have been adopted, the Enrollee's Medicaid Region of residence shall be determined by the adoptive parent's official residence.

Adult Guardianship. For Enrollees who are in adult guardianship status, the county of residence shall be where the Enrollee is living. Brief absences, such as for respite care or hospitalization, not to exceed one month, do not change the county of residence.

The DCBS shall notify the Department when an Enrollee's case is transferred to another area. The Department will include notice of the transfer in the HIPAA 834.

For former foster children under the age of 26 covered by the Expansion of Medicaid by the ACA, the county of residence shall be where the Enrollee is living.

24.6 Primary Care Provider (PCP) Changes

The Contractor shall have written policies and procedures for allowing Enrollees to select or be assigned to a new PCP when such a change is mutually agreed to by the Contractor and Enrollee, when a PCP is terminated from coverage, or when a PCP change is as part of the resolution to an Appeal. The Contractor shall allow Enrollees to select another PCP within ten (10) days of the approved change or the Contractor shall assign a PCP to the Enrollee if a selection is not made within the time frame. Pursuant to 42 C.F.R. 438.52, for Enrollees in a designated rural area in which only the Contractor provides services, the restrictions on changing PCPs cannot be more restrictive than for Enrollee Disenrollment as outlined in Section 27.3 "**Enrollee Request for Disenrollment**."

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An Enrollee shall have the right to change the PCP ninety (90) days after the initial assignment and once a year regardless of reason, and at any time for any reason as approved by the Enrollee's Contractor. The Enrollee may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Enrollee to miss the annual opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Enrollee and/or the PCP are no longer located in the same Medicaid Region.

The Enrollee shall also have the right to change the PCP at any time for cause. Good cause includes the Enrollee was denied access to needed medical services; the Enrollee received poor quality of care; and the Enrollee does not have access to providers qualified to treat his or her health care needs. If the Contractor approves the Enrollee's request, the assignment will occur no later than the first day of the second month following the month of the request.

PCPs shall have the right to request an Enrollee's Disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship; Enrollee has not utilized a service within one year of enrollment in the PCP's practice and the PCP has documented unsuccessful contact attempts by mail and phone on at least six (6) separate occasions during the year; or inability to meet the medical needs of the Enrollee.

PCPs shall not have the right to request an Enrollee's Disenrollment from their practice for the following: a change in the Enrollee's health status or need for treatment; an Enrollee's utilization of medical services; an Enrollee's diminished mental capacity; or, disruptive behavior that results from the Enrollee's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Enrollee or others. Transfer requests shall not be based on race, color, national origin, handicap, age or gender. The Contractor shall have authority to approve all transfers.

The initial PCP shall serve until the new PCP begins serving the Enrollee, barring ethical or legal issues. The Enrollee has the right to file a grievance regarding such a transfer.

The PCP shall make the change for request in writing. Enrollee may request a PCP change in writing, face to face or via telephone.

25.0 Enrollee Grievances and Appeals

25.1 General Requirements

The Contractor shall have an organized grievance system that shall include- a grievance process, an appeals process, and access for Enrollees to a State Fair Hearing pursuant to KRS Chapter 13B and 42 C.F.R. 438 Subpart F. The Department shall provide a standardized form for Contractors to utilize for an Enrollee to begin the Contractor's grievance and appeal process.

25.2 Enrollee Grievance and Appeal Policies and Procedures

The Contractor shall have a timely and organized Grievance and Appeal Process with written policies and procedures for resolving Grievances filed by Enrollees. The Grievance and Appeal Process shall address Enrollees' oral and written grievances. The Grievance and Appeal Process shall be approved in writing by the Department prior to implementation and shall be conducted in compliance with the notice, timelines, rights and procedures in 42 C.F.R. 438 subpart F, 907 KAR 17:010 and other applicable CMS and Department requirements. If federal law and regulation and state law and regulation conflict, federal law and regulation preempts unless the state has been given specific discretion. Grievance and Appeal policies and procedures shall include, but not be limited to:

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A. Provide the Enrollee the opportunity to present evidence, testimony and allegations of fact or law, in person as well as in writing. The Contractor shall inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals and expedited appeals as specified in 42 C.F.R. 438.408(b) and (c);
B. Provide the Enrollee and the Enrollee's representative the Enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor, or at the direction of the Contractor, in connection with the appeal of the adverse benefit determination. This information shall be provided, upon request, free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 C.F.R. 438.408(b) and (c);
C. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination;
D. Consider the Enrollee, the Enrollee's representative, or the legal representative of the Enrollee's estate as parties to the appeal;
E. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization;
F. Procedures for maintenance of records of grievances separate from medical case records and in a manner which protects the confidentiality of Enrollees who file a grievance or appeal;
G. Ensure that a grievance or an appeal is disposed of and notice given as expeditiously as the Enrollee's health condition requires but not to exceed 30 days from its initiation. If the Contractor extends the timeline for an appeal not at the request of the Enrollee, the Contractor shall make reasonable efforts to give the Enrollee prompt oral notice of the delay and shall give the Enrollee written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file another grievance if he or she disagrees with that decision. Additionally, if the Contractor fails to resolve an appeal within this 30-day timeframe, the Enrollee is deemed to have exhausted the Contractor's internal appeal process and may initiate a State Fair Hearing;
H. Ensure individuals and subordinates of individuals who make decisions on grievances and appeals were not involved in any prior level of review;
I. If the grievance or appeal involves a Medical Necessity determination, denial or expedited resolution or clinical issue, ensure that the grievance and appeal is heard by health care professionals who have the appropriate clinical expertise;
J. Process for informing Enrollees, orally and/or in writing, about the Contractor's Grievance and Appeal Process by making information readily available at the Contractor's office, by distributing copies to Enrollees upon enrollment; and by providing it to all subcontractors at the time of contract or whenever changes are made to the Grievance and Appeal Process;
K. Provide assistance to Enrollees in filing a grievance if requested or needed including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability;
L. Include assurance that there will be no discrimination against an Enrollee solely on the basis of the Enrollee filing a grievance or appeal;
M. Include notification to Enrollees in the Enrollee Handbook regarding how to access the Cabinet's ombudsmen's office regarding grievances, appeals and hearings;
N. Provide oral or written notice of the resolution of the grievance in a manner to ensure ease of understanding;
O. Provide for an appeal of a grievance decision if the Enrollee is not satisfied with that decision.
P. Provide for continuation of services, in accordance with 42 C.F.R. 438.420, while the appeal is pending;
Q. Provide expedited appeals relating to matters which could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function;
R. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals to establish the earliest possible filing date for the appeal and must be confirmed in

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writing;

S. Not require an Enrollee or an Enrollee's representative to follow an oral request for an expedited appeal with a written request;
T. Inform the Enrollee of the limited time to present evidence and allegations of fact or law in the case of an expedited appeal;
U. Acknowledge receipt of each grievance and appeal;
V. Provide written notice of the appeal decision in a format and language that, at a minimum, meet the standards described in 42 C.F.R. 438.10 and for notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice;
W. Provide for the right to request a hearing under KRS Chapter 13B;
X. Allows a Provider or a representative to file a grievance or appeal on the Enrollee's behalf as provided in 907 KAR 17.010; and
Y. Notifies the Enrollee that if a Service Authorization Request is denied and the Enrollee proceeds to receive the service and appeal the denial, if the appeal is in the Contractor's favor, that the Enrollee may be liable for the cost as allowed by 42 C.F.R. 438.420(d).

If the Contractor continues or reinstates the Enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

A. The Enrollee withdraws the appeal or request for a State Fair Hearing;
B. The Enrollee does not request a State Fair Hearing with continuation of benefits within ten (10) days from the date the Contractor mails an adverse appeal decision; or
C. A State Fair Hearing decision adverse to the Enrollee is made.

All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department, its designee, or CMS upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

The Contractor shall have procedures for assuring that files contain sufficient information, as outlined at 42 C.F.R. 438.416, to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the Enrollee of receipt of the grievance or appeal, all correspondence between the Contractor and the Enrollee, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Enrollee, and all other pertinent information. Documentation regarding the grievance shall be made available to the Enrollee, if requested.

25.3 State Fair Hearings for Enrollees

. An Enrollee shall exhaust the internal Appeal process with the Contractor prior to requesting a State Fair Hearing. The Contractor, the Enrollee, or the Enrollee's representative or legal representative of the Enrollee's estate shall be parties to the hearing as provided in 907 KAR 17:010(5). An Enrollee may request a State Fair Hearing if he or she is dissatisfied with an adverse benefit determination that has been taken by the Contractor within one hundred and twenty (120) days of the final appeal decision by the Contractor as provided for in 42 C.F.R. 438.408. An Enrollee may request a State Fair Hearing for an adverse benefit determination taken by the Contractor that denies or limits an authorization of a requested service or reduces, suspends, or terminates a previously authorized service. The standard timeframe for reaching a decision in a State Fair Hearing is found in KRS Chapter 13B.

Failure of the Contractor to comply with the State Fair Hearing requirements of the Commonwealth and federal Medicaid law in regard to an adverse benefit determination made by the Contractor or to appear and present evidence shall result in an automatic ruling in favor of the Enrollee.

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The Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but not later than 72 hours from the date the Contractor receives notice reversing the determination, if the services were not furnished while the appeal was pending and the State Fair Hearing results in a decision to reverse the Contractor's decision to deny, limit, or delay services. The Contractor shall pay for disputed services received by the Enrollee while the appeal was pending and the State Fair Hearing reverses a decision to deny authorization of the services.

The Department shall provide for an expedited State Fair Hearing within three (3) days of a request for an appeal that meets the requirements of an expedited appeal after a denial by the Contractor.

26.0 Marketing

26.1 Marketing Activities

The Contractor shall submit any marketing plans and all marketing materials related to the Medicaid managed care program to the Department and shall obtain the written approval of the Department prior to implementing any marketing plan or arranging for the distribution of any marketing materials to potential Enrollees. The Contractor shall abide by the requirements in 42 C.F.R. 438.104 regarding Marketing activities. The Contractor shall establish and at all times maintain a system of control over the content, form, and method of dissemination of its marketing and information materials or any marketing and information materials disseminated on its behalf or through its Subcontractors. The Contractor shall provide marketing materials in English, Spanish, and each prevalent non-English language. The marketing plan shall include methods and procedures to log and resolve marketing Grievances. The Contractor shall conduct mass media advertising directed to Enrollees in the entire state pursuant to the marketing plan.

Marketing by mail, mass media advertising and community oriented marketing directed at potential Enrollees shall be allowed, subject to the Department's prior approval. The Contractor shall be responsible for all costs of mailing, including labor costs.

Any marketing materials referring to the Contactor must be approved in writing by the Department prior to dissemination, including mailings sent only to Enrollees. The Contractor shall engage only in marketing activities that are pre-approved in writing by the Department. The Contractor shall require its Subcontractors to submit any marketing or information materials which relates to this Contract prior to disseminating same. The Contractor shall be responsible for submitting such marketing or information materials to the Department for approval. The Department shall have the same approval authority over such Subcontractor materials as over Contractor materials. The Contractor shall correct problems and errors subsequently identified by the Department after notification by the Department. Any approval required by Section 26.1 "**Marketing Activities"** shall be subject to Section 4.4 "**Approval of Department**."

The Contractor is responsible for ensuring any Enrollee gift card or value added benefit meets the requirements of Social Security Act §1128A, the Contract and any other applicable federal and state laws. Approval of these benefits by the Department shall not be construed as superseding federal or state law.

26.2 Marketing Rules

The Contractor shall abide by the requirements in 42 C.F.R. Section 438.104 regarding Marketing activities. Face to face marketing by the Contractor directed at Enrollees or potential Enrollees is strictly prohibited. In developing marketing materials such as written brochures, fact sheets, and posters, the Contractor shall abide by the following rules:

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A. No marketing materials shall be disseminated through the Contractor's Provider network. If the Contractor supplies branded health education materials to its Provider network, distribution shall be limited to the Contractor's Enrollees and not available to those visiting the Provider's facility. Such branded health education materials shall not provide enrollment or disenrollment information. Any violation of this section shall be subject to the maximum sanction contained in Section 40.5 "Penalties for Failure to Correct."
B. No fraudulent, misleading, or misrepresentative information shall be used in the marketing materials;
C. No offers of material or financial gain shall be made to potential Enrollees as an inducement to select a particular provider or use a product;
D. No offers of material or financial gain shall be made to any person for the purpose of soliciting, referring or otherwise facilitating the enrollment of any Enrollee;
E. No direct or indirect door-to-door, telephone, email, texting or other cold-call marketing activities;
F. All marketing materials comply with information requirements of 42 C.F.R. 438.10; and
G. No materials shall contain any assertion or statement (whether written or oral) that CMS, the federal government, the Commonwealth, or any other similar entity endorses the Contractor.

The following are inappropriate marketing activities, and the Contractor shall not:

A. Provide cash to Enrollees or potential Enrollees, except for stipends, in an amount approved by the Department and reimbursement of expenses provided to Enrollees for participation on committees or advisory groups;
B. Provide gifts or incentives to Enrollees or potential Enrollees unless such gifts or incentives: (1) are also provided to the general public; (2) do not exceed ten dollars per individual gift or incentive; and (3) have been pre-approved by the Department;
C. Provide gifts or incentives to Enrollees unless such gifts or incentives: (1) are provided conditionally based on the Enrollee receiving preventive care or other Covered Services; (2) are not in the form of cash or an instrument that may be converted easily to cash; and (3) have been pre-approved by the Department;
D. Seek to influence a potential Enrollee's enrollment with the Contractor in conjunction with the sale of any private insurance;
E. Induce providers or employees of the Department to reveal confidential information regarding Enrollees or otherwise use such confidential information in a fraudulent manner; or
F. Threaten, coerce or make untruthful or misleading statements to potential Enrollees or Enrollees regarding the merits of enrollment with the Contractor or any other plan.

27.0 Enrollee Eligibility, Enrollment and Disenrollment

27.1 Eligibility Determination

The Department shall have the exclusive right to determine an individual's eligibility for the Medicaid Program and eligibility to become an Enrollee of the Contractor. Such determination shall be final and is not subject to review or appeal by the Contractor. Nothing in this section prevents the Contractor from providing the Department with information the Contractor believes indicates that the Enrollee's eligibility has changed.

27.2 Assignments of New Enrollees

Due consideration shall be given to the following when making assignments for Enrollees who do not select an MCO when enrolling:

A. Keeping the family together - Assign Enrollees of a family to the same MCO.

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B. Continuity of Care - Preserve the family's pre-established relationship with providers to the extent possible.
C. Robust MCO Competition - equitable distribution of the participants among the MCOs.

In order to ensure equitable distribution of Enrollees there will be a MCO maximum threshold and a minimum threshold assigned. Those thresholds shall be developed prior to July 1, 2015, the start date of this Contract. If the Contractor was participating in the Managed Care Program as an MCO prior to entering into this Contract, its current enrollment shall not be reassigned on July 1, 2015. However, the thresholds developed for July 1, 2015 shall apply.

After June 30, 2015, the Department shall follow the steps below for the purpose of equitable distribution.

A. All managed care Enrollees of a Medicaid family will be assigned to the same MCO.
B. Continuity of Care – The Department will use Claims history to determine the most recent, regularly visited primary care physicians (PCP). The top three PCP providers for each Enrollee shall be considered. This determination will be based on the last 12 months of history with relative weights based on the time period of the visits. The weight shall be 1 thru 3 with 3 being assigned to visits in the most recent four months; 1 being assigned to visits in the earliest four-month period, and 2 being assigned to the visits in the middle four-month period. Next, each Enrollee's top three PCP Providers shall be matched against the provider network of the Medicaid Region's MCOs and a "MCO network suitability score" shall be assigned to each family Enrollee.
C. In order to give due consideration to children and individuals with specialized health care needs it is important that all family Enrollees are not treated equally in developing the family unit's overall MCO score. The ratio between the numbers of children eligible for managed care versus the number of adults eligible for managed care is almost 1.9 to 1. Therefore, the "MCO network suitability score" for a child shall be further multiplied by a factor of 1.9. Similarly, individuals with special health care needs (identified as SSI Adults, SSI Children, and Foster Care) shall have their score adjusted by a factor of 1.6 which represents the relative cost of these individuals relative to the cost of adults over 18. In the case of SSI Children and Foster Care both the child factor (1.9) and the special needs factor (1.6) shall be applied. After these adjustments, each family Enrollee's individual "MCO network suitability score" shall be added together to determine the family unit's "MCO network suitability score"
D. The family shall be assigned to the MCO with the highest "MCO network suitability score" unless that MCO has exceeded its maximum threshold. Two maximum thresholds are defined for each Medicaid Region: Families and Children, and Others. If the family unit has both categories of individuals, then both thresholds shall apply. In a scenario where the applicable threshold(s) are exceeded, the family shall be assigned to the MCO with next highest score. If a tie exists between two eligible MCOs, see the following step used.
E. In scenarios where multiple eligible MCOs have the same score for the family "MCO network suitability score", the MCOs which are under the minimum threshold shall be given preference, until the MCO reaches the minimum threshold.
F. In scenarios where multiple MCOs have the same score for the family "MCO network suitability score" and all MCOs are above the minimum threshold, the family shall be assigned on a rotation basis.

27.3 General Enrollment Provisions

The Department shall notify the Contractor of the Enrollees to be enrolled with the Contractor. The Contractor shall provide for a continuous open enrollment period throughout the term of the Contract for newly eligible Enrollees. The Contractor shall not discriminate against potential Enrollees on the basis of an individual's health status, need for health services, race, color, religion, sex, sexual orientation, gender identity, disability or national origin, and shall not use any

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policy or practice that has the effect of discriminating on the basis of an Enrollee's health status, need for health services, race, color, religion, sex, sexual orientation, gender identity, disability or national origin.

The Department shall be responsible for the enrollment. The Department shall develop an enrollment packet to be sent to potential Enrollees. The Contractor shall have an opportunity to review and comment on the information to be included in the enrollment packet, and may be asked to provide material for the enrollment packet.

Enrollees, during the first ninety (90) calendar days after the effective date of initial enrollment, whether the Enrollee selected the Contractor or was assigned through an automatic process, the Enrollee shall have the opportunity to change their Contractor and once a year thereafter in accordance with 42 C.F.R. 438.

27.4 Enrollment Procedures

Each Enrollee shall be provided a Kentucky Medicaid Enrollee Identification Card by the Contractor.

Within five (5) business days after receipt of notification of new Enrollee enrollment, the Contractor shall send a confirmation letter to the Enrollee by a method that shall not take more than three (3) days to reach the Enrollee. The confirmation letter shall include at least the following information: the effective date of enrollment; Site and PCP contact information; how to obtain referrals; the role of the Care Coordinator and Contractor; the benefits of preventive health care; Enrollee identification card; copy of the Enrollee Handbook; and list of covered services. The identification card may be sent separately from the confirmation letter as long as it is sent within five (5) business days after receipt of notification of new Enrollee enrollment.

27.5 Enrollment Levels

The Contractor shall accept all Enrollees, regardless of overall plan enrollment. Enrollment shall be without restriction and shall be in the order in which potential Enrollees apply or are assigned. The Contractor shall maintain staffing and service delivery network necessary to adhere to minimum standards for Covered Services.

Enrollees may voluntarily choose a Contractor. Enrollees who do not select a Contractor shall be assigned to a Contractor by the Department. The Department reserves the right to re-evaluate and modify the auto-assignment algorithm anytime for any reason, provided however, the Department shall provide written notice to Contractor of any modification of the auto-assignment algorithm before the implementation of such modification.

The Department may develop specific limitations regarding Enrollee enrollment with the Contractor to take into consideration quality, cost, competition and adverse selection.

27.6 Enrollment Period

Enrollment begins at 12:01 a.m. on the first day of the first calendar month for which eligibility is indicated on the eligibility file (HIPAA 834) transmitted to the Contractor, and shall remain until the Enrollee is disenrolled in accordance with disenrollment provisions of this Contract. Applicable state and federal law determines Membership for newborns. Membership begins on day of application for Enrollees who are presumptive eligible.

The Contractor shall be responsible for the provision and costs of all Covered Services beginning

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on or after the beginning date of Enrollment. In the event an Enrollee entering is receiving Medically Necessary Covered Services the day before Enrollment, the Contractor shall be responsible for the costs of continuation of such Medically Necessary Covered Services, without any form of prior approval and without regard to whether such services are being provided within or outside the Contractor's Network until such time as the Contractor can reasonably transfer the Enrollee to a service and/or Network Provider without impeding service delivery that might be harmful to the Enrollee's health.

27.7 Enrollee Eligibility File (HIPAA 834)

The Department shall electronically transmit to the Contractor a HIPAA 834 transaction file daily to indicate new, terminated and changed Enrollees and a monthly listing of all Contractor's Enrollees. The Department shall submit with the monthly HIPAA 834 transaction file, a reconciliation of enrollment information pursuant to policies and procedures determined by the Department. The Department shall send the first enrollment data to Contractor in HIPAA 834 format.

All Enrollments and Disenrollments shall become effective on the dates specified on the HIPAA 834 transaction files and shall serve as the basis for Capitated Payments to the Contractor.

The Contractor shall be responsible for promptly notifying the Department of Enrollees of whom it has knowledge were not included on the HIPAA 834 transaction file and shall have been enrolled with the Contractor. Should the Contractor become aware of any changes in demographic information the Contractor shall advise the Enrollee of the need to report information to the appropriate source, i.e. the DCBS office or the Social Security Administration. The Contractor shall not attempt to report these types of changes on behalf of the Enrollee, but shall monitor the HIPAA 834 for appropriate changes. In the event that the change does not appear on the HIPAA 834 within sixty (60) days, Contractor shall report the conflicting information to the Department. The Department shall evaluate and address the inconsistencies as appropriate.

27.8 Persons Eligible for Enrollment and Retroactivity

To be enrolled with a Contractor, the individual shall be eligible to receive Medicaid assistance under one of the aid categories defined below:

Eligible Enrollee Categories

A. Temporary Assistance to Needy Families (TANF);
B. Children and family related;
C. Aged, blind, and disabled Medicaid only;
D. Pass through;
E. Poverty level pregnant women and children, including presumptive eligibility;
F. Aged, blind, and disabled receiving State Supplementation;
G. Aged, blind, and disabled receiving Supplemental Security Income (SSI);
H. Under the age of twenty-one (21) years and in an inpatient psychiatric facility;
I. Children under the age of eighteen (18) who are receiving adoption assistance and have special needs;
J. Dual eligibles;
K. Disabled Children;
L. Foster Care Children;
M. Adults age 19 to 64 with income under 138% of the Federal Poverty Level; or
N. Former Foster Care Children up to age 26.

Enrollees eligible to enroll with the Contractor will be enrolled beginning with the first day of the

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application month with the exception of (1) newborns who are enrolled beginning with their date of birth and (2) presumptively eligible (PE) Enrollees who are eligible on their day of eligibility determination and (3) unemployed parent program Enrollees who are enrolled beginning with the date the definition of unemployment or underemployment in accordance with 45 C.F.R. 233.100 is met. Presumptively Eligible Enrollees will be added to the Contractor's Enrollee Listing Report with an enrollment date equal to the eligibility date described in (2) above.

The Contractor shall also be responsible for providing coverage to individuals who are retroactively determined eligible for Medicaid. Retroactive Medicaid coverage is defined as a period of time up to three (3) months prior to the application month. The Contractor shall cover all medically necessary services provided the Enrollee during the retroactive coverage without a Prior Authorization. The Contractor shall allow a provider to submit a claim outside of the timely filing period when the provider is notified after the end of the Contractor's timely filing period of a retroactive change in MCO by receipt of a recoupment letter, and the Contractor shall not deny the claim based on timely filing.

The Contractor is not responsible for retroactive coverage for SSI Enrollees who are newly enrolled. The Department shall be responsible for previous months or years in situations where an individual appealed a SSI denial, and were subsequently approved as of the original application date and was not already assigned to the Contractor.

27.9 Newborn Infants

Newborn infants of non-presumptive eligible Enrollees shall be deemed eligible for Medicaid and automatically enrolled with the Contractor as individual Enrollees for sixty (60) days. The hospital shall request enrollment of a newborn at the time of birth, as set forth by the Department. Deemed eligible newborns are auto enrolled in Medicaid and enrollment is coordinated within the Cabinet. The delivery hospital is required to enter the birth record in the birth record system called KY CHILD (Kentucky's Certificate of Live Birth, Hearing, Immunization, and Lab Data). That information is used to auto enroll the deemed eligible newborn within twenty-four (24) hours of birth. The Contractor is required to use the newborn's Medicaid ID for any costs associated with child.

27.10 Dual Eligibles

The Contractor shall utilize the HIPAA 834 to identify Enrollees who are Dual Eligible within the MMIS. The Contractor and Medicare Providers shall work together to coordinate the care for such Enrollees in order to reduce over utilization and duplication of services and cost.

27.11 Persons Ineligible for Enrollment

Enrollees who are not eligible to enroll in the Managed Care Program are defined below:

INELIGIBLE ENROLLEE CATEGORIES

A. Individuals who shall spend down to meet eligibility income criteria;
B. Individuals currently Medicaid eligible and have been in a nursing facility for more than thirty (30) days*;
C. Individuals determined eligible for Medicaid due to a nursing facility admission including those individuals eligible for institutionalized hospice;
D. Individuals served under the Supports for Community Living, Michele P, home and community-based, or other 1915(c) Medicaid waivers;
E. Qualified Medicare Beneficiaries (QMBs), specified low income Medicare beneficiaries (SLMBs) or Qualified Disabled Working Individuals (QDWIs);

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F. Timed limited coverage for illegal aliens for emergency medical conditions;
G. Working Disabled Program;
H. Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF-IID);
I. Individuals who are eligible for the Breast or Cervical Cancer Treatment Program; and
J. Individuals otherwise eligible while incarcerated in a correction facility.

* The Contractor shall not be responsible for an Enrollee's nursing facility costs during the first thirty (30) days; however, if an Enrollee is admitted to a nursing facility, the Contractor shall be responsible for covering the costs of health services, exclusive of nursing facility costs, provided to the Enrollee while in the nursing facility until the Enrollee is either discharged from the nursing facility or disenrolled from the Contractor (effective as is administratively feasible). Contractor costs may include those of physicians, physician assistants, APRNs, or any other medical services that are not included in the nursing home facility per diem rate. In no event shall Contractor be responsible for covering the costs of such health services after the Enrollee's 30th day in the nursing facility, and the monthly Capitation Payment for such an Enrollee shall be prorated based upon the days of eligibility. This also applies to an Enrollee receiving hospice services who is transferred into a nursing facility.

The Contractor shall not be responsible for 1915(c) Waiver Services furnished to its Enrollees.

27.12 Reenrollment

An Enrollee whose eligibility is terminated because the Enrollee no longer qualifies for medical assistance under one of the aid categories listed in Section 27.8 "**Persons Eligible for Enrollment"** or otherwise becomes ineligible may apply for reenrollment in the same manner as an initial enrollment.

An Enrollee previously enrolled with the Contractor shall be automatically reenrolled with the Contractor if eligibility for medical assistance is re-established within two (2) months of losing eligibility. The Contractor shall be given a new enrollment date once an Enrollee has been reinstated.

Reenrollment that is more than two (2) months after losing eligibility shall be treated as a new enrollment for all purposes.

The Contractor shall provide reasonable modifications to the annual redetermination process to beneficiaries with disabilities protected by the Americans with Disabilities Act of 1990 (Public Law 101-336), 42 USC 12101, and applicable Federal regulations relating thereto prohibiting discrimination against otherwise qualified disabled individuals under any program or activity; Section 504 of the Rehabilitation Act. The Contractor shall provide reasonable modifications to the obligation to report a change in circumstance for any beneficiary with a disability.

27.13 Enrollee Request for Disenrollment

An Enrollee may request Disenrollment only with cause pursuant to 42 C.F.R. 438.56.

The Enrollee shall submit a written or oral request to request Disenrollment to either the Contractor or the Department giving the reason(s) for the request. If submitted to the Contractor, the Contractor shall transmit the Enrollee's request to the Contract Compliance Officer of the Department. If the Disenrollment request is not granted, the Enrollee may request a state fair hearing. The Department shall notify all Enrollees of their disenrollment rights at least annually no less than 60 days before the start of each enrollment period.

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27.14 Contractor Request for Disenrollment

The Contractor shall recommend to the Department Disenrollment of an Enrollee when the Enrollee pursuant to 42 C.F.R. 438.56:

A. Is found guilty of Fraud in a court of law or administratively determined to have committed Fraud related to the Medicaid Program;
B. Is abusive or threatening as defined by and reported in Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers to either Contractor, Contractor's agents, or providers;
C. Is admitted to a nursing facility for more than 31 days; or
D. Is incarcerated in a correctional facility;
E. No longer qualifies for Medical Assistance under one of the aid categories listed in Section 27.8 "Persons Eligible for Enrollment"
F. Cannot be located.

All requests by the Contractor for the Department to disenroll an Enrollee shall be in writing and shall specify the basis for the request. If applicable, the Contractor's request shall document that reasonable steps were taken to educate the Enrollee regarding proper behavior, and that the Enrollee refused to comply. The Contractor may not request Disenrollment of an Enrollee based on an adverse change in the Enrollee's health, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs, except when his or her continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees.

27.15 Effective Date of Disenrollment

Disenrollment shall be effective on the first day of the calendar month for which the Disenrollment appears on the HIPAA 834 transaction file. Requested Disenrollment shall be effective no later than the first day of the second month following the month the Enrollee or the Contractor files the request. If the Department fails to make a determination within the timeframes the Disenrollment shall be considered approved.

27.16 Continuity of Care upon Disenrollment

The Contractor shall take all reasonable and appropriate actions necessary to ensure the continuity of an Enrollee's care upon Disenrollment. Such actions shall include: assisting in the selection of a new Primary Care Provider, cooperating with the new Primary Care Provider in transitioning the Enrollee's care, and making the Enrollee's Medical Record available to the new the Primary Care Provider, in accordance with applicable state and federal law. The Contractor shall be responsible for following the Transition/Coordination of Care Plan contained in **Appendix I. "Transition/Coordination of Care Plan"** whenever an Enrollee is transferred to another MCO.

27.17 Death Notification

The Contractor shall notify the Department or Social Security Administration in the appropriate county, within five (5) working days of receiving notice of the death of any Enrollee.

27.18 Enrollee Address Verification

The Department reserves the right to disenroll an Enrollee from the Medicaid program if the Department is unable to contact the Enrollee by first class mail and after the Contractor has been

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notified and is unable to provide the Department with a valid address. The Enrollee shall remain disenrolled until either the Department or the Contractor locates the Enrollee and eligibility is reestablished.

28.0 Provider Services

28.1 Required Functions

The Contractor shall maintain a Provider Services function that is responsible for the following services and tasks:

A. Enrolling, credentialing and recredentialing and performance review of providers;
B. Assisting Providers with Enrollee Enrollment status questions;
C. Assisting Providers with Prior Authorization and referral procedures;
D. Assisting Providers with Claims submissions and payments;
E. Explaining to Providers their rights and responsibilities as an Enrollee of Contractor's Network;
F. Handling, recording and tracking Provider Grievances and Appeals properly and timely;
G. Developing, distributing and maintaining a Provider manual;
H. Developing, conducting, and assuring Provider orientation/training;
I. Explaining to Providers the extent of Medicaid benefit coverage including EPSDT preventive health screening services and EPSDT Special Services;
J. Communicating Medicaid policies and procedures, including state and federal mandates and any new policies and procedures;
K. Assisting Providers in coordination of care for child and adult Enrollees with complex and/or chronic conditions;
L. Encouraging and coordinating the enrollment of Primary Care Providers in the Department for Public Health and the Department for Medicaid Services Vaccines for Children Program. This program offers certain vaccines free of charge to Medicaid Enrollees under the age of 21 years. The Contractor is responsible for reimbursement of the administration fee associated with vaccines provided through the program;
M. Coordinating workshops relating to the Contractor's policies and procedures;
N. Providing necessary technical support to Providers who experience unique problems with certain Enrollees in their provision of services;
O. Annually addressing fraud, waste and abuse with providers;
P. Consult with a requesting Provider on authorization decisions, when appropriate; and
Q. Ensures no punitive action is taken against a Provider who either requests an expedited resolution or supports an Enrollee's appeal.

The Contractor shall, no later than January 1, 2019:

A. Establish and operate an interactive website which allows Medicaid providers to file grievances, appeals, and supporting documentation electronically in an encrypted format which complies with Federal and State law and allows a Medicaid provider to review the current status of a matter relating to a grievance or an appeal filed concerning a submitted claim.
B. Upon the request of a Medicaid Provider, provide at no cost to the provider, all documents, records, and other information relevant to an adverse payment or coverage determination, the Contractor shall inform a Medicaid Provider of the determination with sufficient detail of the reason(s) therefore and the Provider's right to request and receive at no cost to the Provider, all documents, records, and other information related to the determination.
C. Provide to each Medicaid Provider the opportunity for an in-person meeting with a representative of the Contractor on any clean claim that remains unpaid in violation of KRS 304.17A-700 t0 304.17A-730; and on any claim that remains unpaid for forty-five (45) days or more after the date on which the claim is received by the Contractor and that individually,

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or in the aggregate, exceeds $2,500.00.

D. Reprocess claims that are incorrectly paid or denied in error, in compliance with KRS 304.17A-708. The Contractor shall not require a Medicaid Provider to rebill or resubmit such a claim in order to obtain correct payment, and no claim shall be denied for timely filing if the claim was timely submitted.

Provider Services shall be staffed, at a minimum, Monday through Friday 8:00 am – 6:00 pm Eastern Time. Staff members shall be available to speak with providers any time during open hours. The Contractor shall operate a provider call center that meets standards as determined by the Department.

Provider Services staff shall be instructed to follow all contractually-required provider relation functions including, policies, procedures and scope of services.

28.2 Provider Credentialing and Recredentialing

The Contractor shall conduct Credentialing and Recredentialing in compliance with National Committee for Quality Assurance standards (NCQA), KRS 205.560(12), 907 KAR 1:672 or other applicable state regulations and federal law. The Contractor shall document the procedure, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat Enrollees. Detailed documentation and scope of the Credentialing and Recredentialing process is contained in **Appendix J. "Credentialing Process."**

The Contractor shall complete the Credentialing or Recredentialing of a Provider within ninety (90) calendar days of receipt of all relative information from the Provider, or within forty-five (45) days if the Provider is providing substance use disorder services. The status of pending requests for credentialing or recredentialing shall be submitted as required in **Appendix J.** "**Credentialing Process.**"

Unless prohibited by NCQA standards, if the Contractor allows the Provider to provide covered services to its Enrollees before the credentialing or recredentialing process is completed and the Provider is credentialed, the Contractor shall allow the Provider to be paid for the period from the date of its application for credentials to completion of the credentialing or recredentialing process.

If the Contractor accepts the Medicaid enrollment application on behalf of the provider, the Contractor will use the format provided in **Appendix J. "Credentialing Process"** to transmit the listed provider enrollment data elements to the Department. A Provider Enrollment Coversheet will be generated per provider. The Provider Enrollment Coversheet will be submitted electronically to the Department.

The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.

The Contractor shall provide a credentialing process whereby the Provider is only required to go through one credentialing process that applies to the Contractor and any or all of its Subcontractors, if one credentialing process meets NCQA requirements.

28.3 Implementation of a Credentialing Verification Organization (CVO)

The Contractor shall comply with and take all necessary actions to implement the requirements of 2018 Ky.Acts Ch. 69 and all other applicable Federal and State laws. The Contractor shall work with any identified CVO designated by the Department.

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28.4 Provider Credentialing and Recredentialing

The Contractor shall conduct Credentialing and Recredentialing in compliance with NCQA, KRS 205.560(12), 907 KAR 1:672 and other applicable state regulations and federal law. The Contractor shall document the procedure, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat Enrollees. Detailed documentation and scope of the Credentialing and Recredentialing process is contained in **Appendix J. "Credentialing Process."**

The Contractor shall complete the Credentialing or Recredentialing of a Provider within forty-fiv (45) calendar days of receipt of all relative information from the Provider.The status of pending requests for credentialing or recredentialing shall be submitted as required in **Appendix J.** "**Credentialing Process.**"

Unless prohibited by NCQA standards, if the Contractor allows the Provider to provide covered services to its Enrollees before the credentialing or recredentialing process is completed and the Provider is credentialed, the Contractor shall allow the Provider to be paid for the period from the date of its application for credentials to completion of the credentialing or recredentialing process.

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The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.

The Contractor shall provide a credentialing process whereby the Provider is only required to go through one credentialing process that applies to the Contractor and any or all of its Subcontractors, if one credentialing process meets NCQA requirements.

28.5 Primary Care Provider Responsibilities

A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a FQHC, FQHC look-alike, primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals. Primary care physician residents may function as PCPs. The PCP shall serve as the Enrollee's initial and most important point of contact with the Contractor. This role requires a responsibility to both the Contractor and the Enrollee. Although PCPs are given this responsibility, the Contractors shall retain the ultimate responsibility for monitoring PCP actions to ensure they comply with the Contractor and Department policies.

Specialty providers may serve as PCPs under certain circumstances, depending on the Enrollee's needs, including for an Enrollee who has a gynecological or obstetrical health care need, a disability, or chronic illness. The decision to utilize a specialist as the PCP shall be based on agreement among the Enrollee or family, the specialist, and the Contractor's medical director. The Enrollee has the right to Appeal such a decision in the formal Appeals process.

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The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's policies including but not limited to the following:

A. Maintaining continuity of the Enrollee's health care;
B. Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the Contractor's network;
C. Maintaining a current medical record for the Enrollee, including documentation of all PCP and specialty care services;
D. Discussing Advance Medical Directives with all Enrollees as appropriate;
E. Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years;
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and
G. Arranging and referring Enrollees when clinically appropriate, to behavioral health providers.

Maintaining formalized relationships with other PCPs to refer their Enrollees for after-hours care, during certain days, for certain services, or other reasons to extend the hours of service of their practice. The PCP remains solely responsible for the PCP functions (A) through (G) above.

The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by PCPs in Contractor's Network and that the unacceptable arrangements are not implemented:

A. Acceptable:
    1. Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;
    2. Office phone is answered after hours by a recording directing the Enrollee to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and
    3. Office phone is transferred after office hours to another location where someone shall answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.
B. Unacceptable:
    1. Office phone is only answered during office hours;
    2. Office phone is answered after hours by a recording that tells Enrollees to leave a message;
    3. Office phone is answered after hours by a recording that directs Enrollees to go to the emergency room for any services needed; and
    4. Returning after-hours calls outside of thirty (30) minutes.

28.6 Provider Manual and Communications

The Contractor shall prepare and issue a Provider Manual(s), including any necessary specialty manuals (e.g. Behavioral Health) to all network Providers. For newly contracted providers, the Contractor shall issue copies of the Provider Manual(s) within five (5) working days from inclusion of the provider in the network or provide online access to the Provider Manual and any changes or updates. All Provider Manuals shall be available in hard copy format and/or online.

Department shall approve the Provider Manual, including any provided by a subcontractor for direct services, and any updates to the Provider Manual, prior to publication and distribution to Providers. Such approval is subject to Section 4.4 "**Approval of Department**."

The Provider Manual and updates shall serve as a source of information to Providers regarding

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Covered Services, Contractor's Policies and Procedures, provider credentialing and recredentialing, including Enrollee Grievances and Appeals, claims submission requirements, reporting fraud and abuse, prior authorization procedures, Medicaid laws and regulations, telephone access, the QAPI program, standards for preventive health services and other requirements when identified by the Contractor.

The Contractor shall prepare and issue provider communications as necessary to inform providers about Contractor's policies, initiatives or other information. The Department shall approve prior to distribution provider communications only if they change or amend the way the MCO conducts business with the provider. Such approval is subject to Section 4.4 "**Approval of Department**." An example of a provider communication requiring approval is notification of a rate change.

28.7 Provider Orientation and Education

The Contractor shall conduct initial orientation for all Providers within thirty (30) days after the Contractor places a newly contracted Provider on an active status. The Contractor shall ensure that all Providers receive initial and ongoing orientation in order to operate in full compliance with the Contract and all applicable Federal and Commonwealth requirements. The Contractor shall use reasonable efforts to ensure that all Providers receive targeted education for specific issues identified by the Department. The Contractor shall ensure that provider relations staffing ratios are proportionally adequate to address provider's issues in a timely manner. The Contractor shall maintain and make available upon request enrollment or attendance rosters dated and signed by each attendee or other written evidence of training of each Provider and their staff. The Contractor shall ensure that Provider education includes: Contractor coverage requirements for Medicaid services; policies or procedures and any modifications to existing services, reporting fraud and abuse; Medicaid populations/eligibility; standards for preventive health services; special needs of Enrollees in general that affect access to and delivery of services; Advance Medical Directives; EPSDT services; Claims submission and payment requirements; special health/care management programs that Enrollees may enroll in; cultural sensitivity; responding to needs of Enrollees with mental, developmental and physical disabilities; reporting of communicable disease; the Contractors QAPI program; medical records review; EQRO and; the rights and responsibilities of both Enrollees and Providers. The Contractor shall ensure that ongoing education is conducted relating to findings from the QAPI program when deemed necessary by either the Contractor or Department.

28.8 Provider Educational Forums

The Contractor shall participate in any Medicaid Provider Educational Forums designated by the Department to be held throughout the State as enhanced education efforts related to Medicaid managed care. The Contractor shall remit to the Department Ten Thousand ($10,000) Dollars at the start of each fiscal year under this Contract to support this outreach effort.

28.9 Provider Maintenance of Medical Records

The Contractor shall require their Providers to maintain Enrollee medical records on paper or in an electronic format. Enrollee medical records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.

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The Enrollee's medical record is the property of the Provider who generates the record. However, each Enrollee or their representative is entitled to one free copy of his/her medical record. Additional copies shall be made available to Enrollees at cost. Medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records are required to be kept for a person's lifetime).

The Contractor shall ensure that the PCP maintains a primary medical record for each Enrollee, which contains sufficient medical information from all providers involved in the Enrollee's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:

A. Enrollee/patient identification information, on each page;
B. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;
C. Date of data entry and date of encounter;
D. Provider identification by name;
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;
F. Past medical history, including serious accidents, operations, illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);
G. Identification of current problems;
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;
I. Documentation of immunizations pursuant to 902 KAR 2:060;
J. Identification and history of nicotine, alcohol use or substance abuse;
K. Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;
L. Follow-up visits provided secondary to reports of emergency room care;
M. Hospital discharge summaries;
N. Advanced Medical Directives, for adults;
O. All written denials of service and the reason for the denial; and
P. Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.

An Enrollee's medical record shall include the following minimal detail for individual clinical encounters:

A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;
B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits;
C. Plan of treatment including:
    1. Medication history, medications prescribed, including the strength, amount, directions for use and refills;
    2. Therapies and other prescribed regimen; and
    3. Follow-up plans including consultation and referrals and directions, including time to return.

An Enrollee's medical record shall include at a minimum for hospitals and mental hospitals:

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A. Identification of the beneficiary.
B. Physician name.
C. Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 42 C.F.R. 456.172 (mental hospitals) or 42 C.F.R. 456.70 (hospitals).
   Initial and subsequent continued stay review dates (described under 42 C.F.R. 456.233 and 42 C.F.R. 465.234 (for mental hospitals) and 42 C.F.R. 456.128 and 42 C.F.R. 456.133 (for hospitals)
D. Reasons and plan for continued stay if applicable.
E. Other supporting material appropriate to include.
F. For non-mental hospitals only:
   1. Date of operating room reservation.
   2. Justification of emergency admission if applicable.

28.10 Advance Medical Directives

The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 - 311.643 and 42 C.F.R. Part 489, Subpart I and 42 C.F.R. 422.128, and 438.10 Advance Medical Directives, including living wills or durable powers of attorney for health care, allow adult Enrollees to initiate directions about their future medical care in those circumstances where Enrollees are unable to make their own health care decisions. The Contractor shall, at a minimum, provide written information on Advance Medical Directives to all Enrollees and shall notify all Enrollees of any changes in the rules and regulations governing Advance Medical Directives within ninety (90) Days of the change and provide information to its PCPs via the Provider Manual and Enrollee Services staff on informing Enrollees about Advance Medical Directives. PCPs have the responsibility to discuss Advance Medical Directives with adult Enrollees at the first medical appointment and chart that discussion in the medical record of the Enrollee.

28.11 Provider Grievances and Appeals

The Contractor shall implement a process to ensure that a Provider shall have the right to file an internal appeal with the Contractor regarding denial of a health care service or claim for reimbursement, provider payment or contractual issues. The Contractor shall provide written notification to the Provider regarding a denial. The Department shall provide a standard Provider Grievance Form to be used by the Contractor to initiate its provider grievance process. Appeals received from Providers that are on the Enrollee's behalf for denied services with requisite consent of the Enrollee are deemed Enrollee appeals and not subject to this Section.

Contractor shall log Provider appeals. Appeals shall be recorded in a written record and logged with the following details: date, nature of Appeal, identification of the individual filing the Appeal, identification of the individual recording the appeal, disposition of the Appeal, corrective action required and date resolved. Provider grievances or appeals shall be resolved and the Provider shall receive in writing the resolution within thirty (30) calendar days. If the grievance or appeal is not resolved within thirty (30) days, the Contractor shall request a fourteen (14) day extension from the Provider. If the Provider requests the extension, the extension shall be approved by the Contractor. The Contractor shall ensure that there is no discrimination against a Provider solely on the grounds that the Provider filed an Appeal or is making an informal Grievance. The Contractor shall monitor and evaluate Provider Grievances and Appeals. The Contractor shall submit monthly reports to the Department regarding the number, type and outcomes including final denials of Provider Grievances and Appeals as required in **Appendix K. "Reporting Requirements and Reporting Deliverables.**"

A Provider who has exhausted the Contractor's internal appeal process shall have a right to appeal a final denial, in whole or in part, by the Contractor to an external independent third party

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in accordance with applicable state laws and regulations including denials, in whole or in part, involving emergency care services. The Contractor shall provide written notification to the Provider of its right to file an appeal. A provider shall have a right to appeal a final decision by an external independent third party to the Cabinet for Health and Family Services Division of Administrative Hearings for a hearing in accordance with applicable state laws and regulation. If the Provider prevails, in whole or in part, the Contractor shall comply with any Final Order within sixty (60) days unless the Final Order designates a different timeframe.

28.12 Other Related Processes

The Contractor shall provide information specified in 42 C.F.R. 438.10(g)(2)(XI) about the grievance and appeal system to all service providers and subcontractors at the time they enter into a contract.

28.13 Release for Ethical Reasons

The Contractor shall not require Providers to perform any treatment or procedure that is contrary to the Provider's conscience, religious beliefs, or ethical principles in accordance with 42 C.F.R. 438.102.

The Contractor shall have a referral process in place for situations where a Provider declines to perform a service because of ethical reasons. The Enrollee shall be referred to another Provider licensed, certified or accredited to provide care for the individual service, or assigned to another PCP licensed, certified or accredited to provide care appropriate to the Enrollee's medical condition.

A release for ethical reasons only applies to Contractor's Network Providers; it does not apply to the Contractor.

The Contractor shall not prohibit or restrict a Provider from advising an Enrollee about his or her health status, medical care or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.

29.0 Provider Network

29.1 Network Providers to Be Enrolled

In accordance with 42 C.F.R. 438.206(b)(1)(i)-(v), when establishing and maintaining its network of Providers, the Contractor shall consider the anticipated Medicaid enrollment; the expected utilization of services, given the characteristics and health care needs of the specific Medicaid populations enrolled with the Contractor; the numbers and types (their training, experience, and specialization) of Providers required to provide the necessary Medicaid services; the numbers of network Providers who are not accepting new Medicaid patients; and the geographic location of Providers and its Enrollees, considering distance, travel time, the means of transportation ordinarily used by its Enrollees, and whether the location provides physical access for its Enrollees with disabilities. The Contractor shall maintain, by written agreements, its network of Providers.

The Contractor's Network shall include Providers from throughout the provider community. The Contractor shall comply with the any willing provider statute as described in 907 KAR 1:672 or as amended and KRS 304.17A-270. Neither the Contractor nor any of its Subcontractors shall require a Provider to enroll exclusively with its network to provide Covered Services under this Contract as such would violate the requirement of 42 C.F.R. Part 438 to provide Enrollees with continuity of care and choice. The Contractor shall enroll at least one (1) Federally Qualified

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Health Centers (FQHCs) and one (1) Rural Health Clinic into its network for each Medicaid Region where available and at least one teaching hospital.

In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, psychiatrists, advanced practice registered nurses, physician assistants, free-standing birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, speech language pathologists, physical therapists, occupational therapists, private duty nursing agencies, pharmacies, durable medical equipment suppliers, podiatrists, renal dialysis clinics, ambulatory surgical centers, family planning providers, emergency medical transportation provider, non-emergency medical transportation providers as specified by the Department, other laboratory and x-ray providers, individuals and clinics providing Early and Periodic Screening, Diagnosis, and Treatment services, chiropractors, community mental health centers, psychiatric residential treatment facilities, hospitals (including acute care, critical access, rehabilitation, and psychiatric hospitals), local health departments, and providers of EPSDT Special Services. The Contractor shall also enroll Psychologists, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Behavioral Health Services Organizations, Certified Family, Youth and Peer Support Providers, Licensed Clinical Social Workers, Targeted Case Managers, Chemical Dependency Treatment Centers, Residential Crisis Stabilization Units, Licensed Clinical Alcohol and Drug Counselors, Multi-Therapy Agencies (agencies providing physical, speech and occupational therapies which include Comprehensive Outpatient Rehabilitation Facilities, Special Health Clinics, Mobile Health Services, Rehabilitation Agencies and Adult Day Health Centers) and other independently licensed behavioral health professionals. The Contractor may also enroll other providers, which meet the credentialing requirements, to the extent necessary to provide covered services to the Enrollees. Enrollment forms shall include those used by the Kentucky Medicaid Program as pertains to the provider type. The Contractor shall use such enrollment forms as required by the Department.

The Department will continue to enroll hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, FQHC, RHC and hospices. The Medicaid provider file will be available for review by the Contractor so that the Contractor can ascertain the status of a Provider with the Medicaid Program and the provider number assigned by the Kentucky Medicaid Program.

Providers performing laboratory tests are required to be certified under the CLIA. The Department will continue to update the provider file with CLIA information from the CASPER/QIES file formally known as OSCAR provided by the Centers for Medicare & Medicaid Services for all appropriate providers. This will make laboratory certification information available to the Contractor on the Medicaid provider file.

The Contractor shall have written policies and procedures regarding the selection and retention of Contractor's Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.

If the Contractor declines to include individuals or groups of providers in its network, it shall give affected providers written notice of the reason for its decision.

The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.

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29.2 Out-of-Network Providers

The Department will provide the Contractor with an expedited enrollment process to assign provider numbers for providers not already enrolled in Medicaid for emergency situations only.

29.3 Contractor's Provider Network

All providers in the Contractor's network shall be enrolled in the Kentucky Medicaid Program. The Contractor may enroll providers in their network who do not provide services to the fee-for-service population. Providers shall meet the credentialing standards described in Section 28.2 "**Provider Credentialing and Re-Credentialing** of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type.

The Contractor shall provide written notice to Providers not accepted into the network along with the reasons for the non-acceptance. A provider cannot enroll or continue participation in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.

29.4 Enrolling Current Medicaid Providers

The Contractor will have access to the Department's Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid Provider number as the provider identifier when transmitting information or communicating about any provider to the Department or its Fiscal Agent. The Contractor shall transmit a file of Provider data specified in this Contract for all credentialed Providers in the Contractor's network on a monthly basis and when any information changes.

29.5 Enrolling New Providers and Providers Not Participating in Medicaid

A provider is not required to participate in the Kentucky Medicaid Fee-for-Service Program as a condition of participation with the Contractor's Network but must be enrolled in the Kentucky Medicaid Program. If a potential Provider has not had a Medicaid number assigned, the provider shall apply for enrollment with the Department and meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. When the Contractor has submitted the required data in the transmission of the provider file indicating inclusion in the Contractor's Network, the Department will enter the provider number on the master provider file and the transmitted data will be loaded to the provider file. The Contractor will receive a report within two weeks of transactions being accepted, suspended or denied.

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All documentation regarding a provider's qualifications and services provided shall be available for review by the Department or its agents at the Contractor's offices during business hours upon reasonable advance notice.

29.6 Termination of Network Providers

A. The Contractor shall terminate from participation any Provider who (i) engages in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) has a license, certification, or accreditation terminated, revoked or suspended; (iii) has medical staff privileges at any hospital terminated, revoked or suspended; or (iv) engages in behavior that is a danger to the health, safety or welfare of Enrollees.

   The Department shall notify the Contractor of suspension, termination, and exclusion actions taken against Medicaid providers by the Kentucky Medicaid program within three (3) business days via e-mail. The Contractor shall terminate the Provider effective upon receipt of notice by the Department.

B. The Contractor shall notify the Department via email of a Provider termination from the Contractor's network within three (3) business days for the following reasons:
   1. Adverse Medicare Action
   2. Adverse Action on Professional License;
   3. Deceased;
   4. Professional License Surrender; and
   5. Other State Medicaid Adverse Action.

   The notification should contain the reason, a brief description of the Provider's actions and/or applicable information leading to termination, the NPI, Medicaid ID, Entity Name, Provider Type (two digit) and complete mailing address. The Contractor shall send the email notification to the Division off Program Integrity, Provider Enrollment Branch Manager and any applicable designee(s). The Contractor shall notify any Enrollee of the Provider's termination provided such Enrollee has received a service from the terminated Provider within the previous six months. Such notice shall be mailed within fifteen (15) days of the action taken if it is a PCP and within thirty (30) days for any other Provider.

   The Contractor will report all terminations monthly via the Provider Termination Report as referenced in Appendix K. "Reporting Requirements and Reporting Deliverables." The Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceased participation. The Contractor shall notify any Enrollee of the Provider's termination provided such Enrollee has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i.) thirty (30) days prior to the effective date of the termination or (ii) within fifteen (15) days of receiving notice.

   The Contractor shall notify any Enrollee of the Provider's termination provided such Enrollee has received a service from the terminated Provider within the previous six months. Such notice shall be mailed within fifteen (15) days of the action taken if it is a PCP and within thirty (30) days for any other Provider.

C. The Contractor may terminate from participation any Provider who materially breaches the Provider Agreement with Contractor and fails to timely and adequately cure such breach in accordance with the terms of the Provider Agreement.

   The Contractor shall notify any Enrollee of the Provider's termination provided such Enrollee

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has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) within fifteen (15) days of providing notice or (ii) thirty (30) days prior to the effective date of the termination.

29.7 Provider Program Capacity Demonstration

The Contractor shall assure that all covered services are as accessible to Enrollees (in terms of timeliness, amount, duration, and scope) as the same services are available to commercial insurance Enrollees in the Medicaid Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Enrollees of medically-necessary services. The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section. Emergency medical and behavioral health services shall be made available and accessible to Enrollees twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any provider in the Contractor's Program shall be made available and accessible within 48 hours of request. The Contractor shall provide the following:

A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Enrollee residence in urban areas, and for Enrollees in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Enrollee residence; with an Enrollee to PCP (FTE) ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of an Enrollee's request for routine and preventive services and forty-eight (48) hours for Urgent Care.
B. If either the Contractor or a Provider (including Behavioral Health) requires a referral before making an appointment for specialty care, any such appointment shall be made within thirty (30) days for routine care or forty-eight (48) hours for Urgent Care.
C. In addition to the above, the Contractor shall include in its network Specialists designated by the Department; and include sufficient pediatric specialists to meet the needs of Enrollees younger than twenty-one (21) years of age. Access to Specialists shall not exceed sixty (60) miles or sixty (60) minutes. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty-eight (48) hours for urgent care.
D. Immediate treatment for any Emergency Medical or Behavioral Health Services by a health provider that is most suitable for the type of injury, illness, or condition, regardless of whether the facility is in Contractor's Network.
E. Access to Hospital care shall not exceed thirty (30) miles or thirty (30) minutes, except in non-urban areas where access may not exceed sixty (60) miles or sixty (60) minutes, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed sixty (60) miles or sixty (60) minutes.
F. Access for general dental services shall not exceed sixty (60) miles or sixty (60) minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty-eight (48) hours for urgent care.
G. Access for general vision, laboratory and radiology services shall not exceed sixty (60) miles or sixty (60) minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty-eight (48) hours for Urgent Care.
H. Access for Pharmacy services shall not exceed thirty (30) miles or thirty (30) minutes.
I. In addition to any Community Mental Health Center or Local Health Department which the Contractor has in its network, the Contractor shall include in its network Mental Health and Substance Abuse providers for both adults and children in no fewer number than fifty (50%) percent of the Mental Health and Substance Abuse providers enrolled in the Medicaid program to provide out-patient, intensive out-patient, substance abuse residential, case management, mobile crisis, residential crisis stabilization, assertive community treatment and peer support services..
J. The Department shall notify the Contractor and all other MCOs on contract with the

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Department when more than five (5%) percent of Emergency Room visits in a Medicaid Region, in a rolling three (3) month period, are determined to be a non-emergent visit. The Contractor shall provide sufficient alternate sites for twenty-four (24) hour care and appropriate incentives to Enrollees to reduce unnecessary Emergency Room visits so that the determination of non-emergent visits are reduced to no more than two (2%) percent in a rolling three (3) month period for that Medicaid Region. The Contractor and all other MCOs shall provide such alternate sites or incentives based upon the number of their respective Enrollees in the Medicaid Region.

29.8 Additional Network Provider Requirements

A. The Contractor shall attempt to enroll the following Providers in its network as follows:
   1. Teaching hospitals;
   2. FQHCs and rural health clinics;
   3. The Kentucky Commission for Children with Special Health Care Needs
   4. Community Mental Health Centers;
   5. Pediatric Prescribed Extended Care Providers

   If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Enrollees without contracting with these specified providers. Such approval is subject to Section 4.4 “Approval of Department.”

B. In consideration of the role that Department for Public Health, which contracts with the local health departments, plays in promoting population health of the provision of safety net services, the Contractor shall offer a participation agreement to the Department of Public Health for local health department services. Such participation agreement shall include, but not be limited to, the following provisions:
   1. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.
   2. Provide reimbursement at rates commensurate with those provided under Medicare.

   The Contractor is encouraged to work with the Department for Public Health on the Diabetes Self-Management Program and the Diabetes Prevention Program

   The Contractor may also include any charitable providers which serve Enrollees in the Medicaid Region, provided that such providers meet credentialing standards.

C. The Contractor shall demonstrate the extent to which it has included providers who have traditionally provided a significant level of care to Medicaid Enrollees. The Contractor shall have participating providers of sufficient types, numbers, and specialties to assure quality and access to health care services as required for the Quality Improvement program as outlined in Management Information Systems. If the Contractor is unable to contract with the providers listed in this subsection, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in the Contract shall be available to meet the needs of its Enrollees. Such approval is subject to Section 4.4 “Approval of Department.”

29.9 Provider Network Adequacy

The Contractor shall submit information in accordance with **Appendix L. “MCO Provider Network File Layout”** that demonstrates that the Contractor has an adequate network that meets the Department’s standards in Section 29.7 “**Provider Program Capacity Demonstration**.” The Contractor shall notify the Department, in writing, of any anticipated

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network changes that may impact network standards as defined herein.

The Contractor shall update this information to reflect changes in the Contractor's Network monthly. Unless the request is as a result of a determination under Section 29.10 "**Expansion and/or Changes in the Network"** that the Contractor is not in compliance with the access standards, the Contractor shall have thirty (30) days to produce documentation on changes to its Network.

29.10 Expansion and/or Changes in the Network

If at any time, the Contractor or the Department determines that its Contractor Network is not adequate to comply with the access standards specified above for 95% of its Enrollees, the Contractor or Department shall notify the other of this situation and within fifteen (15) business days the Contractor shall submit a corrective action plan to remedy the deficiency. Providers in the Contractor's Network who will not accept Medicaid Enrollees shall not be included in the assessment as to whether the Contractor's Network is adequate to comply with access standards. The corrective action plan shall describe the deficiency in detail, including the geographic location where the problem exists, and identify specific action steps to be taken by the Contractor and time-frames to correct the deficiency.

In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make reasonable efforts to recruit additional providers based on Enrollee requests. When Enrollees ask to receive services from a provider not currently enrolled in the network, the Contractor shall contact that provider to determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.

29.11 Provider Electronic Transmission of Data

The Contractor shall transmit any additions or changes to the Contractor's Network as specified in **Appendix L. "MCO Provider Network File Layout"."** Encounter Record containing provider numbers that are not on the Medicaid master provider file will not be accepted.

29.12 Provider System Specifications and Data Definitions

Appendix L. "MCO Provider Network File Layout" contains the file layouts, data element definitions, and other information relevant to maintenance of the provider file by Contractor.

29.13 Maintaining Current Provider Network Information for Enrollees

In addition to providing changes to the Provider Network to the Department, the Contractor shall ensure that all changes to the Provider Network are communicated to Enrollees within ten (10) business days of such change. Correcting the Provider Directory maintained by the Contractor on its website within ten (10) business days of such changes shall be deemed in compliance with this provision. The Contractor shall update a paper provider directory at least monthly.

In accordance with 42 C.F.R. 438.10(h), the Provider Directory shall include the following for physicians, hospitals, pharmacies, behavioral health providers:

A. Provider's name as well as any group affiliation;
B. Street address;
C. Telephone number(s);
D. Website URL, as appropriate;
E. Specialty, as appropriate;

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F. Whether the provider will accept new Enrollees;
G. Provider's cultural and linguistic capabilities including languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training; and
H. Whether the provider's office/facility has accommodations for people with physical disabilities including offices, exam rooms and equipment.

29.14 Cultural Consideration and Competency

The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity. The Contractor shall address the special health care needs of its Enrollees needing culturally sensitive services. The Contractor shall incorporate in policies, administration and service practice the values of: recognizing the Enrollee's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Enrollee's cultural background. The Contractor shall communicate such policies to Subcontractors.

30.0 Provider Payment Provisions

30.1 Claims Payments

The Contractor shall accept only the uniform claim forms submitted from providers that have been approved by the Department and completed according to Department guidelines. The Contractor shall accept claims submitted directly to the Contractor by the Provider. The Contractor shall ensure that payments are made to the appropriate provider.

30.2 Prompt Payment of Claims

In accordance with 42 C.F.R. 447.46, the Contractor shall comply with the timely claims payment requirements of 42 C.F.R. 447.45. The Contractor shall implement Claims payment procedures that ensure 90% of all Provider Claims, including to I/T/Us, for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) days of the date of receipt of such Claims and that 99% of all Claims are processed within ninety (90) days of the date of receipt of such Claims. In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and KRS 304.99-123, as may be amended. The date of receipt is the date the MCO receives the claim, as indicated by its date stamp on the claim or other notation as appropriate to the medium used to file a claim and the date of payment is the date of the check or other form of payment.

The Contractor shall notify the requesting provider of any decision to deny a Claim or to authorize a service in an amount, duration, or scope that is less than requested.

Any conflict between federal law and Commonwealth law will default to the federal law unless the Commonwealth requirements are stricter.

30.3 Payment to Out-of-Network Providers

The Contractor shall reimburse Out-of-Network Providers in accordance with Section 30.1 "**Claims Payments**" for the following Covered Services:

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A. Specialty care for which the Contractor has approved an authorization for the Enrollee to receive services from an Out-of-Network Provider;
B. Emergency Care that could not be provided by the Contractor's Network Provider because the time to reach the Contractor's Network Provider would have resulted in risk of serious damage to the Enrollee's health;
C. Services provided for family planning;
D. Services for children in Foster Care; and
E. Pharmacy services.

The above listed Covered Services shall be reimbursed at no more than 100 percent of the Medicaid fee schedule/rate.

30.4 Payment to Providers for Serving Dual Eligible Enrollees

The Contractor shall coordinate benefits for Dual Eligible Enrollees by paying the lesser amount of:

A. The Contractor's allowed amount minus the Medicare payment, or
B. The Medicare co-insurance and deductible up to Contractor's allowed amount.

In the event that Medicaid does not have a price for codes included on a crossover claim then the entire Medicare coinsurance and deductible shall be paid by the Contractor. The Contractor shall further assist Dual Eligible Enrollees in coordination of benefits required under Section 4.3 "**Delegations of Authority**."

30.5 Payment of Federally Qualified Health Centers ("FQHC") and Rural Health Clinics ("RHC")

The Contractor shall assure that payment for services provided to FQHCs and RHCs is not less than the level and amount of payment the Contractor would make for the services if the services were furnished by other clinic or primary care Providers. The Department shall reimburse, by making payments directly to FQHCs and RHCs, the difference if the rate is less than the amount paid under Kentucky's established prospective payment system (PPS) rate for the federally certified facilities. The Department may not pay an FQHC and RHC in excess of the PPS rate. The Contractor may also limit payment to the PPS rate.

The Contractor shall report to the Department within forty-five (45) calendar days of the end of each quarter the total amount paid to each FQHC and RHC per month. The report shall include the provider number, name, total number of paid claims per month, total amount paid by Contractor, and any adjustments. If the Contractor fails to submit the information within the required timeframe, there shall be a penalty of $500 per day until the information is received.

30.6 Commission for Children with Special Needs

The case management and care coordination needs of the medically complex children serviced by the Commission for Children with Special Needs must be recognized by the Contractor in that a special payment rate shall be developed for the Commission by a process of negotiation between the Contractor and the Commission. The rate to be established shall be not less than seventy-eight (78) percent of the Medicaid allowable cost based on the most recent available cost report of the Commission and shall be subject to negotiation at annual intervals.

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30.7 Payment of Teaching Hospitals

In establishing payments for teaching hospitals in the Contractor's Network, the Contractor shall recognize total costs for graduate medical education at state owned or operated teaching hospitals, including adjustments required by KRS 205.565

30.8 Intensity Operating Allowance

The Department and the Contractor acknowledge and agree that Contractor is subject to the legislatively mandated intensity operating allowance and hospital rate increase. Contractor shall receive capitation payments that reflect these mandated items. (See 907 KAR 10:830)

30.9 Urban Trauma

The Contractor shall agree that payment for Urban Trauma Center amount is contingent upon the Commonwealth's receipt of the necessary state matching funds from the Urban Trauma Provider to support such payment and shall so do in a manner necessary to meet all federal requirements governing such transactions. (See 907 KAR 10:830)

30.10 Critical Access Hospitals

The Contractor shall reimburse Critical Access Hospitals at rates that are at least equal to those established by CMS for Medicare reimbursement to a critical access hospital in accordance with 907 KAR 10:815.

30.11 Supplemental Payments

The Department and Contractor recognize the Department's desire to provide enhanced reimbursement to provider entities through supplemental payments in order to preserve the ability of the provider entities to provide essential services to Commonwealth residents.

Supplemental payments in addition to adjudicated claims payments are made to a number of specified provider entities. Those categories of providers receiving supplemental payments are as follows:

A. Intensity Operating Allowance for Pediatric Teaching hospitals
B. A State Designated Urban Trauma Center
C. State Owned or Operated University Teaching Hospital Faculty
D. Psychiatric Access Supplement to a Designated Psychiatric Hospital

Descriptions of these payments are found in other sections of the contract. State owned or operated university teaching hospitals include a hospital operated by a related party organization as defined in 42 C.F.R. 413.17, which is operated as part of an approved School of Medicine or Dentistry.

Supplemental payments will be made in accordance with 42 C.F.R. 438.6(d). The Department will make payments to the Contractor, through the monthly capitation payment in accordance with Appendix A, for the supplemental payments the Contractor shall pay the specified providers. The Department will notify the Contractor of the amount of the monthly supplemental payment. Contractor shall make monthly supplemental payments to the specified providers on or before the last business day of the month of service for which capitation is paid. Six (6) months following the end of this Contract, the Department or its designee will reconcile the supplemental payments between the Department and the Contractor based on Total Enrollee Months during the Contract

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period with run out through the June, 2018 capitation cycle. The Department will make a final supplemental payment or recoup payments from the Contractor as determined by the reconciliation. The Contractor shall pay any additional funds due the specified providers or recoup from the providers based on the Department's determination.

The Contractor agrees, upon the request of the Department, to submit to the Department claims-level cost data for payment verification purposes. Contractor will work with the Department to assure that information is provided to allow for provider entities to remit the state matching portion of the payments to the Department, as applicable.

30.12 Independence of Provider Reimbursement Rates and Methodologies

Unless explicitly stated elsewhere in this Contract, the Department does not direct the Contractor's expenditures for services provided under this Contract, and reimbursement rates and methodologies for services provided under this Contract are at the sole discretion of the Contractor.

30.13 Notice to Providers on Change of Reimbursement

The Contractor shall give at least thirty (30) days written notice to Providers prior to any change in payment structure or reimbursement amount. The written notice must contain clear and detailed information about the change. Changes in reimbursement to current Covered Services shall not be retroactive. The Contractor is responsible for updating their system to accept new codes covered by The Department and delete expired codes regardless of when they are added to or deleted from The Department's fee schedules.

31.0 Covered Services

31.1 Medicaid Covered Services

The Contractor shall provide Covered Services in an amount, duration, and scope that is no less than the amount, duration, and scope furnished Medicaid recipients under fee-for-service program, and for Enrollees under the age of twenty-one (21) as set forth in 42 C.F.R. 441 Subpart B; that are reasonably expected to achieve the purpose for which the services are furnished; enables the Enrollee to achieve age-appropriate growth and development; and enables the Enrollee to attain, maintain, or regain functional capacity. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

The Contractor may establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees; may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan, and applicable regulations, such as medical necessity; and place appropriate limits on a service for utilization control, provided the services furnished can reasonably be expected to achieve their purpose, services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports, and family planning services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning.

The Contractor shall provide, or arrange for the provision of Covered Services to Enrollees in accordance with the state Medicaid plan, state regulations, and policies and procedures applicable to each category of Covered Services. The Contractor shall ensure that the care of new Enrollees is not disrupted or interrupted. The Contractor shall ensure continuity of care for new Enrollees receiving health care under fee for service prior to enrollment in the Plan.

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Appendix H. "Covered Services" shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Enrollees. However, it is not intended, nor shall it serve as a substitute for the more detailed information relating to Covered Services which is contained in the State Medicaid Plan, applicable administrative regulations governing Kentucky Medicaid services and individual Medicaid program services manuals incorporated by reference in the administrative regulations.

After the Execution Date, to the extent a new or expanded Covered Service is added by the Department to Contractor's responsibilities under this Contract, ("New Covered Service") the financial impact of such New Covered Service will be evaluated from an actuarial perspective by the Department, and Capitation Rates to be paid to Contractor hereunder will be adjusted, if necessary, accordingly to Sections 11.2 "**Rate Adjustments**" and 41.3 "**Amendments**". The determination that a Covered Service is a New Covered Service is at the discretion of the Department. At least ninety (90) days before the effective date of the addition of a New Covered Service, the Department will provide written notice to Contractor of any such New Covered Service and any adjustment to the Capitation Rates herein as a result of such New Covered Service. This notice shall include: (i) an explanation of the New Covered Service; (ii) the amount of any adjustment to Capitation Rates herein as a result of such New Covered Service; and (iii) the methodology for any such adjustment.

The Contractor may provide, or arrange to provide, services in addition to the services described above provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.

For any Medicaid service provided by the Contractor that requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be completed according to the appropriate Kentucky Administrative Regulation (KAR). The Contractor shall require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request.

The Contractor shall not prohibit or restrict a Provider from advising an Enrollee about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.

If the Contractor is unable to provide within its network necessary **Covered Services,** it shall timely and adequately cover these services out of network for the Enrollee for as long as Contractor is unable to provide the services in accordance with 42 C.F.R. 438.206. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will ensure that cost to the Enrollee is no greater than it would be if the services were provided within the Contractor's Network.

An Enrollee who has received Prior Authorization from the Contractor for referral to a specialist physician or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's Network, to the extent reasonable and appropriate.

31.2 Direct Access Services

The Contractor shall make Covered Services available and accessible to Enrollees as specified in this Contract. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's network. If so, the Contractor shall enroll the provider as soon as the necessary

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procedures have been completed. When an Enrollee wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.

The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by an Enrollee for the following services within the Contractor's Network:

A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;
D. Maternity care for Enrollees under eighteen (18) years of age;
E. immunizations to Enrollees under twenty-one (21) years of age;
F. Sexually transmitted disease screening, evaluation and treatment;
G. Tuberculosis screening, evaluation and treatment;
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;
I. Chiropractic services;
J. For Enrollees with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs; and
K. Women's health specialists.

The Contractor shall ensure direct access and may not restrict the Enrollee's access to services in accordance with 42 C.F.R. 438 and applicable state statutes and regulations.

31.3 Second Opinions

At the Enrollee's request, the Contractor shall provide for a second opinion related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions, within the Contractor's network, or arrange for the Enrollee to obtain a second opinion outside the network without cost to the Enrollee. The Contractor shall inform the Enrollee, in writing, at the time of Enrollment of the Enrollee's right to request a second opinion.

31.4 Billing Enrollees for Covered Services

The Contractor and its Providers and Subcontractors shall not bill an Enrollee for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this Contract. Any Provider who knowingly and willfully bills an Enrollee for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.

However, if an Enrollee agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Enrollee. The standard release form signed by the Enrollee at the time of services does not relieve the Contractor, Providers and Subcontractors from the prohibition against billing a Medicaid Enrollee in the absence of a knowing assumption of liability for a Non-Medicaid Covered Service. The form or other type of acknowledgement relevant to Medicaid Enrollee liability must specifically state the services or procedures that are not covered by Medicaid.

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31.5 Referrals for Services Not Covered by Contractor

When it is necessary for an Enrollee to receive a Medicaid service that is outside the scope of the Covered Services provided by the Contractor, the Contractor shall refer the Enrollee to a provider enrolled in the Medicaid fee-for-service program. The Contractor shall have written policies and procedures for the referral of Enrollees for Non-Covered Services that shall provide for the transition to a qualified health care provider and, where necessary, assistance to Enrollees in obtaining a new Primary Care Provider. The Contractor shall submit any desired changes to the established written referral policies and procedures to the Department for review and approval subject to Section 4.4 "**Approval of Department**."

31.6 Interface with State Behavioral Health Agency

A. Contractor's Behavioral Health Director or designee will meet with the Department and DBHDID no less than quarterly to discuss State Mental Health Authority and Single State (substance abuse) Agency (SSA) protocols, rules and regulations including but not limited to:
   1. Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) operating definitions
   2. Other priority populations
   3. Targeted Case Management, Community Support Associate, and Peer Support provider certification training and process
   4. Satisfaction survey requirements
   5. Priority training topics (e.g. trauma-informed care, suicide prevention, co-occurring disorders, evidence-based practices)
   6. Behavioral health services hotline
   7. Behavioral health crisis services (referrals; emergency, urgent and routine care)
B. Contractor will coordinate:
   1. Enrollee education process for individuals with serious mental illnesses (SMI) and children and youth with serious emotional disturbances (SED) with the Department. Contractor will provide the Department and DBHDID with proposed materials and protocols.
   2. With the Department, DBHDID and CMHCs a process for integrating Behavioral Health Services' hotlines with processes planned by the Contractor to meet system requirements.
   3. With the Department on establishing collaborative agreements with state operated or state contracted psychiatric hospitals, as well as with other Department facilities that individuals with co-occurring behavioral health and developmental and intellectual disabilities (DID) use.

31.7 Provider-Preventable Diseases

The Contractor shall not pay a Provider for provider-preventable conditions that meet the following criteria:

A. Is identified in the State Medicaid plan;
B. Has been found by the Department, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
C. Has a negative consequence for the Enrollee;
D. Is auditable; and
E. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

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The Contractor shall require all Providers to report provider-preventable conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made. The Contractor shall report all identified provider-preventable conditions in a form or frequency as specified by the Department.

31.8 Mental Health Parity

The Contractor and its providers must comply with the Mental Health Parity and Addiction Equity Act of 2008 and 42 C.F.R. 438 Subpart K, including the requirements that treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Contractor and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

31.9 Institutions for Mental Disease (IMD) Expansion

In accordance with 42 C.F.R. 438.3(e)(2), the Contractor may cover services or settings in lieu of services or settings covered under the State Plan, including an inpatient stay in an IMD for psychiatric or substance use disorder, for Enrollees aged 21 through 64 for a short term stay up to the number of days permitted by CMS.

A. The services and settings will be reimbursable and subject to the requirements of 42 C.F.R. Part 438.
B. Per 42 C.F.R. 438.3(e)(2)(ii), the Contractor may not require an Enrollee to receive services in an IMD.
C. The Contractor shall track the number of days of the Enrollee's stay in an IMD during a calendar month. If the Enrollee's stay exceeds 15 calendar days in a given month, the Contractor shall notify the Department within five (5) business days.
D. The Enrollee will remain in the Contractor's plan. For months when the Enrollee's stay exceeds 15 days, the Contractor will receive a pro-rated capitation payment for the days the Enrollee is not in the IMD. The rate to be paid for the days in the IMD shall be at the Contractor's negotiated rate between the Contractor and the provider.

32.0 Pharmacy Benefits

This section serves to clarify additional requirements specifically related to the Contractor's administration of pharmacy benefits on behalf of the Department.

32.1 Pharmacy General Requirements

The Contractor shall administer pharmacy benefits in accordance with this section, other requirements specified in this Contract, and in accordance with all applicable State and Federal laws and regulations. In accordance with the Contractor's Formulary and/or Preferred Drug List, the Contractor shall provide coverage for all medically necessary legend and non-legend drugs once a drug becomes FDA approved and eligible for manufacturer federal rebates in accordance with Section 1927 of the Social Security Act, and ensure the availability of quality pharmacy services for all Enrollees.

Pharmacy benefit requirements shall include, but not be limited to:

A. State-of-the-art, online and real-time rules-based point-of-sale (POS) claims processing services with prospective drug utilization review (ProDUR) and edits;
B. An accounts receivable (A/R) process that includes records for the Department to

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systematically track adjustments, recoupments, manual payments, and other required identifying A/R and claim information;

C. Retrospective drug utilization review (RetroDUR) services;
D. Formulary and non-formulary services, including but not limited to, prior authorization (PA) services, a PA escalation process and procedure, an appeals process, and a Pharmacy and Therapeutics Committee;
E. Pharmacy Provider relations and education, and call center services (Enrollee and Provider), in addition to Provider services specified elsewhere;
F. Seamless interfaces with the information systems of the Department and as needed, any related vendors;
G. Claims payment services;
H. Reporting and analysis to assist in monitoring and managing the pharmacy program and ensuring compliance with all Federal and State requirements;
I. Assisting the Department by cooperating and providing support during internal and external audits, including CMS certification or reviews, or transitions or upgrades of any MMIS/MEMS systems; and
J. Pursuant to Section 1903(i) of the Social Security Act, all handwritten or computer generated/printed Medicaid prescriptions shall require one or more approved industry-recognized tamper-resistant features to prevent all three (3) of the following:
    1. Copying of a completed or blank prescription form;
    2. Erasure or modification of information written on the prescription pad by the prescriber; AND
    3. Use of counterfeit prescription forms.

This requirement does not pertain to prescriptions received by fax, telephone, or electronically.

32.2 Response Time for Pharmacy-Related Matters

The Contractor shall cooperate with the Department as needed regarding pharmacy-related matters and shall respond to Department staff telephone calls or emails no later than three (3) hours or within the time requested in urgent or emergency cases as determined by the Department.

32.3 Covered Outpatient Drugs

The Contractor shall provide coverage of covered outpatient drugs and prescribed drugs as defined in Section 1927 of the Social Security Act, that meets the standard of coverage imposed by Section 1927 as if such standards applied directly to Contractor. If the Contractor's formulary does not provide coverage of a drug that is otherwise covered by Kentucky Medicaid for individuals in the FFS program, the Contractor shall ensure access and coverage to the off-formulary covered outpatient or prescribed drug in the same manner as Kentucky Medicaid FFS and in accordance with the prior authorization requirements of Section 1927.

32.4 Physician Administered Drugs

The Contractor shall be responsible for reimbursement of physician administered drugs and biologics. Claims for drug products obtained and/or administered in an office/clinic or other non-institutional setting and processed via Contractor's medical benefit shall contain a valid National Drug Code (NDC) and other necessary information such as a HCPCS code (J-Code, Q-Code, A-Code) and appropriate billable units. If such claims are processed via Contractor's point of sale system, then such claims shall be NCPDP compliant. Any claim for a physician administered drug shall satisfy all requirements for encounter submission and acceptance and meet all rebate invoicing requirements regardless of processing format.

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32.5 Formulary and/or Preferred Drug List

The Contractor shall maintain a drug formulary and/or preferred drug list (PDL) which follows the general and minimum requirements herein:

A. The formulary and/or PDL shall:
   1. Be made available to Providers and Enrollees, including the tier for each medication and other information as necessary;
   2. Only exclude coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act as amended by the Omnibus Budget Reconciliation Act (OBRA) of 1993;
   3. Be developed by a P&T that shall represent the Enrollees including those with special needs;
   4. For each therapeutic drug class, the selection of drugs included shall be sufficient to ensure the availability of covered drugs with the least need for prior authorization; and
   5. Not be used for the sole purpose to deny coverage of any Medicaid covered outpatient drug.
   6. Be reviewed on a rolling basis so that all represented classes are reviewed within at least a three (3) year period.
B. If the formulary and/or PDL prefers generic equivalents, Contractor shall provide a brand name exception process for prescribers to use when medically necessary.
C. Publication of formulary and/or PDL:
   1. Contractor shall publish and make available via hard copy upon request, online/webpage or web portal, or by other relevant means of communication its current formulary and/or PDL to all Providers and Enrollees.
   2. Formulary and/or PDL drug lists shall be made available on Contractor's web site in a machine readable file and format as specified in 42 C.F.R. section 438.10.
   3. The formulary and/or PDL shall be updated by the Contractor throughout the year and shall reflect changes such as, status of a drug, adds or deletes. Updates to the formulary and/or PDL shall be distributed in the formats herein mentioned no later than the effective date of changes.

So long as the Contractor complies with the requirements of Section 1927, Contractor may adopt different formularies and/or PDLs than those of the Department and apply different utilization management tools or practices such as, but not limited to, prior authorization requirements.

32.6 Alignment of Clinical Criteria and Pharmacy Based Programs and Initiatives

To assist the Department in its efforts to address some of Kentucky's greatest health concerns; including but not limited to Hepatitis and substance use disorders, the Contractor shall, when and as directed by the Department, align with Department sponsored clinical criteria, pharmacy based programs and other initiatives. The Department may at any time during this Contract notify the Contractor of drug class or specific drug product clinical criteria, pharmacy based programs, or initiatives focused on drug utilization or outcomes. The Contractor shall align its criteria and processes and comply with such requirements no later than ninety (90) calendar days after written notification is sent from the Department. Any systems or policy and process changes required to implement new requirements shall be made at no cost to the Department.

32.7 Reimbursement Rates and Dispensing Fees

The Department shall set, create, or approve, and may change at any time for any reason, reimbursement rates between the Contractor or a pharmacy benefit manager or administrator or the like subcontractor and a pharmacy Provider, or an entity which contracts on behalf of a pharmacy. Reimbursement rates shall include dispensing fees which take into account applicable

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CMS guidance. The pharmacy benefit manager or administrator or the like subcontracted by the Contractor shall notify the Department directly or through the Contractor no less than thirty (30) calendar days in advance of any proposed change of over five percent (5%) in the product reimbursement rates for a pharmacy Provider licensed in the state. The Department may disallow such a change by notifying the Contractor at any time prior to the implementation date of the change. If the Department disallows the proposed change, the Contractor shall require its subcontracted pharmacy benefit manager or administrator or the like to reprocess all affected claims without undue delay at the old reimbursement rate.

The Department may consider any information ascertained pursuant to this Contract in the setting, creation, or approval of reimbursement rates and dispensing fees subject to this section.

Beginning on the effective date of this Contract and pursuant to 18 RS HB 200, Medicaid Benefits, section (16), the Contractor shall comply and ensure that any subcontractor engaged to reimburse for drug products through POS/retail claims complies with all dispensing fee requirements set by this Contract. The Contractor shall or shall cause and ensure its subcontracted agent or entity to pay an additional dispensing fee of two dollars ($2.00) without reduction of any kind or for any reason. This additional dispensing fee amount shall be in addition to the dispensing fee remitted to pharmacies for POS/retail claims as calculated or determined by contractual provisions negotiated directly with the dispensing pharmacy or any entity who contracts on behalf of the dispensing pharmacy whether negotiated by the Contractor, any subcontracted pharmacy benefit manager or administrator or the like.

32.8 Pharmacy and Therapeutics Committee

The Contractor shall utilize a Pharmacy and Therapeutics Committee (P&T) in accordance with KAR Title 907. The P&T shall meet in Kentucky periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the PDL or drug formulary. The P&T shall be considered an advisory committee to a public body thereby making it subject to Kentucky's Open Meetings Law found in KRS 61.800 to 61.850. Prior to each new calendar year, the Contractor shall give notice to the Department of the time, date and location of the P&T meetings. The Contractor shall make every reasonable effort to ensure that meeting dates and times for the P&T do not conflict with the meeting times for other MCO P&T or FFS P&T meetings. This shall be for the purpose of allowing attendance and travel for interested parties and the Department's pharmacy staff. Final decisions are to be posted and maintained on the Contractor's pharmacy information webpage and/or web portal.

32.9 Pharmacy Claims Payment Administration

All claims adjudicated as payable shall be for eligible Enrollees, to enrolled Providers, for approved services, and in accordance with the payment rules and other policies, regulations, and statutes of the Department.

The Contractor shall:

A. Ensure the POS system satisfies the functional and informational requirements by:
   1. Supporting the POS function for claims submissions by pharmacies twenty-four (24) hours per day, three hundred and sixty-six (366) days per year (except for scheduled and approved downtime).
   2. Providing the ability to apply an Internal Control Number (ICN) to each claim and its supporting documentation, regardless of submission format. This unique number is used to cross reference the ICN for tracking, claims, research, reconciliation, or audit purposes.
   3. Ensuring appropriate HIPAA safeguards are in place to protect the confidentiality of

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client information.

4. Ensuring the system is capable of adding, changing, or removing claim adjudication processing rules to accommodate State and Federal required changes to the pharmacy program within sixty (60) days, unless otherwise approved.

B. Process, adjudicate, and pay Kentucky Medicaid pharmacy claims, including voids and full or partial adjustments, via an online, real-time POS system by:
   1. Using the specified current National Council for Prescription Drug Program (NCPDP) format. Required updates to this format shall be at no cost to the Department;
   2. Identifying and denying claims that contain invalid Provider numbers including where the Taxonomy/National Provider Identifier (NPI) or Provider number is missing or is invalid. Claims containing errors shall be returned to the originating Provider;
   3. Identifying Providers on all pharmacy claims by their specific NPI; Drug Enforcement Administration (DEA) numbers, Taxonomy, or any other identifying number as required by CHFS, the Department, or HIPPA shall be captured by the Provider files;
   4. Utilizing a system that has the functionality to process claims requiring International Classification of Diseases Ninth Revision (ICD-9) and International Classification of Diseases Tenth Revision (ICD-10) codes; and
   5. Validating claims to identify any liable third party (e.g. Medicare), and ensure that Medicaid is the payer of last resort.

C. Pay ninety-five percent (95%) of all clean claims submitted by network and non-network pharmacy Providers within twenty-one (21) calendar days of receipt and one hundred percent (100%) of all claims in thirty (30) calendar days.
   1. The term "pay" means either send the Provider cash or cash equivalent in full satisfaction of the clean claim, or give the Provider a credit against any outstanding balance owed by that Provider to the Contractor.
   2. The term “clean claim” means a properly completed paper or electronic claim submitted in compliance with NCPDP standards and approved for payment.
   3. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.
   4. Contractor shall pay the claim or advise the Provider that the claim submitted is denied and specify all reasons for the denial.

D. Contractor shall also provide the ability to process claims on batch electronic media and paper claims submitted directly for processing. Paper claims may include, but not limited to, those submitted in situations when an Enrollee has to visit an out-of-network pharmacy in an emergency. Paper claims shall be submitted on the NCPDP UCF version D.0.
   1. Contractor shall process and adjudicate paper claims within ten (10) calendar days of receipt.
   2. Contractor shall assign ICNs to all batch claims within twenty-four (24) hours of receipt.
   3. Contractor shall maintain electronic backup of batch claims for the duration of the contract.
   4. Electronic batch claims shall be adjudicated through the same processing logic as the POS claims.

E. Claims (837) and Remittance Advices (R/A) (835) shall use the American National Standards Institute (ANSI) X12 Electronic Data Interface (EDI) standard required for HIPAA compliance.

F. Contractor shall notify the Department in writing no later than one (1) calendar day from discovery of any POS processing and/or claims adjudication issue that is or has the potential to significantly impact processing time for claims submissions, claims adjudication, and/or continuity of Enrollee drug therapy. A significant impact means for this purpose a threshold of one hundred (100) or more Enrollees impacted by the issue. Notification shall be followed by a written explanation of the root cause and corrective action.

G. Contractor shall establish a unique Medicaid-specific Processor Identification (BIN)/Issuer Identification Number (IIN), Processor Control Number (PCN), and Group Number combination for POS pharmacy claims processing, to ensure Medicaid claims are not the same as Contractor’s commercial and/or Medicare Part D business lines.

H. Contractor shall develop, maintain and distribute to Providers a procedure and billing

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manual that lists detailed billing instructions.

32.10 Drug Utilization Review (DUR) Program

The Contractor shall operate a drug utilization review (DUR) program that complies with the requirements described in Section 1927(g) of the Social Security Act and 42 C.F.R. Part 456, Subpart K, and as required by the Department, as if such requirements applied directly to Contractor instead of the Department. The Contractor's DUR program shall satisfy the minimum requirements for prospective and retrospective DUR as described in Section 1927(g) of the Social Security Act, amended by the OBRA of 1990, and as followed herein.

A. DUR standards shall ensure that Providers screen for allergies, idiosyncrasies, chronic conditions that may relate to drug utilization, potential drug therapy problems, and provide counseling to the Enrollee in accordance with existing pharmacy laws and federal regulations.
B. DUR standards shall also encourage proper drug utilization by ensuring maximum compliance, minimizing potential fraud, waste and abuse, and taking into consideration both the quality and cost of the pharmacy benefit.
C. Contractor shall include review of mental health/substance use and narcotic drugs in its DUR program.
D. The DUR services and activities shall include, but not be limited to:
    1. Monitoring, managing and profiling prescribing patterns;
    2. Educating contracted Providers regarding compliance to formulary and/or PDL and appropriate prescribing practices; and
    3. Administering intervention practices with the goal of improving prescribing patterns for contracted Providers:
        a. Whose prescribing patterns or practices appear to be operating outside of industry or peer norms or as may be defined by the Department;
        b. Who are noncompliant as it relates to formulary and/or PDL adherence and/or generic prescription patterns; and/or
        c. Who are failing to follow required PA processes and procedures.
E. Reports and/or results of DUR program reviews shall be provided where applicable to Contractor's network Providers.
F. A DUR program shall include current clinical standards for each category of DUR, i.e. therapeutic duplication, drug-drug interaction, disease-drug interactions, maximum daily dosage, and therapy duration.
G. If at any time during this Contract DUR requirements are revised to align with State or federal laws, regulations or guidance, or Department policy, Contractor shall make all necessary changes to remain in compliance.

The Contractor shall provide a detailed description of its drug utilization review program activities to the Department on an annual basis. The actual date shall be determined by the Department and in sufficient time to gather the information necessary to comply with and time submit the CMS Annual DUR report. The Contractor shall provide all data necessary for appropriate CMS Annual DUR Report submissions including, but not limited to, completing the Contractor's portion of the actual annual report template furnished by CMS and within the requested timeframe.

32.11 Pharmacy Drug Rebate Administration

Pursuant to the Affordable Care Act and 42 C.F.R. 438.3(s), CMS requires States to collect CMS level rebates on all Medicaid MCO utilization. In order for the Department to comply with this requirement the Contractor shall be required to report timely drug utilization data that is necessary for the Department to bill manufacturers for rebates in accordance with section 1927 (b) (1) (A) of the Social Security Act no later than forty-five (45) calendar days or as required by the Department after the end of each quarterly rebate period. Therefore, covered outpatient or

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prescribed drugs dispensed by Contractor to Enrollees, including diabetic testing supplies, insulin, and those drug products administered by network Providers in an office/clinical or other non-institutional setting, are subject to the same manufacturer rebate requirements as Kentucky Medicaid FFS outpatient drugs. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, date of service (date of dispense), paid date (actual date claim was paid) and package size by NDC of each covered outpatient drug and prescribed drug dispensed or covered by the Contractor's plan. The Contractor shall submit this NDC level information on drugs, biologics, and other Provider administered products, including, but not limited to drug codes (e.g. J-Code/Q-Code/A-Code), units and conversions consistent with federal and Department requirements. The Department or its designated contractor shall provide this claims level detail to manufacturers to assist in dispute resolutions. However, since the Department is not the POS Claims processor, resolutions of unit disputes are dependent upon cooperation of the Contractor. The Contractor shall assist the Department in resolving drug rebate disputes with the manufacture.

If at any time during this Contract, requirements are revised to align with State or federal laws, regulations or guidance, Contractor shall make all changes necessary to remain in compliance.

32.12 340B Transactions

The Contractor shall submit all drug encounters including physician administered drugs, with the exception of in-patient hospital drug encounters, to the Department pursuant to the requirements of this Contract. The Contractor shall maintain the systems capability and methodology to appropriately identify 340B claims in real time, prospectively, and retrospectively. The Contractor shall support all Department based efforts and initiatives for 340B claim identification at a claim level of detail, including the utilization of the NCPDP fields designed for this purpose. Contractor shall require pharmacy Providers or processing vendors to identify 340B purchased drugs on claims in accordance with Department requirements.

The Department shall deliver notice of billing guide changes to Contractor as necessary and with implementation deadlines. If program changes occur, these shall be at no cost to the Department.

32.13 Pharmacy Prior Authorizations

The Contractor shall conduct a Prior Authorization (PA) program that complies with the requirements of section 1927(d)(5) of the Social Security Act and with Department requirements, as if such requirements apply to the Contractor instead of the Department.

The Contractor's PA program shall ensure there is no undue disruption of an Enrollee's access to care; shall prevent penalization of the Provider or Enrollee, financially or otherwise, for such PA requests or approvals; and shall incorporate the minimum requirements described herein:

A. Clinical PA review criteria shall be aligned with FDA approved indications, best clinical practice standards, and/or other national standards.
B. A physician peer review shall be available upon a Provider's request for any denial made at a pharmacist review level.
C. PA determinations including those from escalated reviews shall be made and communicated to the requesting Provider within twenty-four (24) hours from the initial request including weekends in compliance with the provisions of OBRA 1990 mandate, Section 1927 of the Social Security Act, and other federal regulations.
D. All PA activities and decisions shall be documented in Contractor's online pharmacy case management system. This information shall be available for immediate review at the Department's request or other timeframe as specified by the Department.
E. In the event a prescription is for a drug awaiting PA and the pharmacy cannot reach the

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prescribing physician, and when the dispensing pharmacist using reasonable clinical judgment deems it necessary to avoid imminent harm or injury to the Enrollee, a seventy-two (72) hour emergency supply shall be provided. If the physician prescribed an amount of drug that is less than a seventy-two (72) hour supply but is packaged so that it must be dispensed intact, the pharmacist may dispense the packaged drug and Contractor shall pay for this quantity even if it exceeds a calculated seventy-two (72) hour supply. Contractor shall instruct the pharmacy Providers how to perform the override in the NCPDP environment of the POS pharmacy claims processing system.

F. Contractor's PA process shall include procedures for Enrollee appeals and grievances submitted by the Enrollee or the prescriber authorized to act on behalf of the Enrollee related to PAs denied after the final escalated review. Contractor's procedures for PA related appeals and grievances shall be in accordance with Section 25.2 Enrollee Grievance and Appeal Policies and Procedures and Section 28.9 Provider Grievances and Appeals of this Contract.
G. Adverse benefit determinations shall comply with the timely and adequate notice requirements of 42 C.F.R. section 438.10 and section 438.404.
H. The Department shall provide a universal prior authorization form for the Contractor to utilize for a Provider to initiate the pharmacy prior authorization process. The Contractor shall give the Provider the option to use the designated Kentucky Medicaid pharmacy universal form or a Contractor specific form. Although the Contractor may seek additional information before making determination on a particular prior authorization request, all such information shall be requested from the Provider by way of a supplemental prior authorization information sheet that does not duplicate information found on the Kentucky Medicaid universal pharmacy prior authorization form. The Contractor shall not deny a prior authorization request submitted on the designated universal pharmacy prior authorization form and require the provider to submit the Contractor specific form but rather shall suspend the request while awaiting a supplemental information sheet.
I. The Contractor shall make prior authorization determinations in a timely and consistent manner so that Enrollees with comparable medical needs receive a comparable and consistent level, amount, and duration of pharmacy services as supported by the Enrollee's medical condition, records, and previous affirmative coverage decisions.
J. The Contractor shall comply with any reporting requests made by the Department within this contracting period to assist the Department in accessing the process and outcomes of the Contractor's prior authorization policies and practices.

32.14 Maximum Allowable Cost and Transparency

The Contractor shall establish and maintain a generic drug Maximum Allowable Cost (MAC) program in order to promote generic utilization and cost containment. The Contractor shall update MAC and other pricing benchmarks on a schedule at least as consistent as is required by CMS for Medicare Part D plans found at 42 C.F.R. 423.505(b)(21) or State law.

The Contractor shall specify in all applicable Provider and/or Subcontractor/vendor agreements entered into or amended after the effective date of this Contract, including its PBM, to manage or control the cost of the prescription drug coverage provided by the Contractor's health plan that the MAC program requirements herein shall apply. Specifically, the Contractor and any pharmacy benefit manager or administrator or like subcontractor shall comply with all maximum allowable cost laws and administrative regulations promulgated by DOI, or the Department. The Contractor shall be accountable for any Subcontractor noncompliance with the MAC program requirements herein or otherwise promulgated by State or federal law.

32.15 Specialty Pharmacy and Pharmacy Drugs

The Contractor shall comply with industry standards for the management of specialty pharmacy drugs. Characteristics of specialty drugs may include the following:

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A. Drugs that are used to treat and diagnose rare and complex diseases;
B. Drugs that require close clinical monitoring and management;
C. Drugs that frequently require special handling;
D. Drugs of a high dollar amount for a standard dosage; or
E. Drugs that may have limited access or distribution.

The Contractor may establish a Specialty Pharmacy Network, subject to any Willing Provider specifications outlined in federal and/or State laws or regulations. The Contractor's criteria for network participation shall be readily available.

32.16 Pharmacy Call Center Services

In addition to any other Provider Services required herein, the Contractor shall operate a toll-free pharmacy call center twenty-four (24) hours a day, three-hundred and sixty-six (366) days per year for access by Providers.

The Department may monitor the call center through review of statistical reports, telephone calls, or onsite visits. The Contractor shall have a tracking system that retains information taken on each call and is retrievable using personal information for the individual from whom the call was received. The information shall be provided to the Department upon request.

Call Center capabilities shall include:

A. Producing an electronic record to document all calls, including, but not limited to, PA requests and claims processing;
B. Providing a complete record of communication to the call line from Providers and other parties;
C. Providing an escalation procedure whereby a caller not satisfied with the response received may pursue a resolution; and
D. Ensuring compliance with HIPAA confidentiality requirements.

The Contractor shall provide a quality assurance program to sample calls and make follow-up calls to monitor caller satisfaction.

32.17 Interfaces Maintained

The Contractor shall maintain the following systems:

A. An effective interface between the MMIS/MEMS and the Contractor's system(s) for pharmacy claims processing;
B. A dedicated communication line connecting the MMIS/MEMS to the Contractor's processing site. The cost of this communication line is to be solely at the expense of the Contractor. This dedicated communication line shall meet specifications of the Department; and
C. The ability to accept transaction data that changes baseline MMIS/MEMS files on a daily basis unless the Department approves a more/less frequent schedule.
    1. The file transfer schedule shall, at a minimum, result in the daily update of the POS system with the most current information from the MMIS/MEMS. This may include, but not be limited to, Enrollee eligibility, PA information, and Provider file(s) or reference information;
    2. The interface between Contractor's system(s) and the MMIS/MEMS system shall be compatible;
    3. The Contractor shall adhere to all Change Management requirements prior to implementing any changes to existing or new interfaces from the MMIS/MEMS; and
    4. The Contractor shall update all MMIS/MEMS data without manual intervention, unless

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approval from the Department is provided.

NOTE: Federal regulations require the Department to maintain appropriate controls over POS eligibility contractors who perform both switching services and billing services. Switch and billing agent functions, if provided by the same company, shall be maintained as separate and distinct operations. If the contractor serving as the POS contractor also provides services as the Providers' agent, an organizational firewall shall be in place to separate these functions.

32.18 Provider Education

The Contractor shall develop, implement, and conduct ongoing educational programs for Kentucky Medicaid pharmacy Provider community. These educational initiatives shall include, but not be limited to:

A. Provider letters and bulletins.
B. PDL drug changes and distribution.
C. POS messaging.
D. Training sessions, webinars, quarterly newsletters, and other training activities as requested by the Department.
E. Billing instructions and claim resolution.
F. Website postings of the PDL.
G. PA processes and procedures.

The Contractor shall cooperate with the Department and/or other Contractors as needed regarding pharmacy-related matters.

32.19 Pharmacy Directors Meeting

Pursuant to Section 9.3 Monthly meetings, Contractor's Pharmacy Director shall meet monthly with the Department and other Contractors like personnel to discuss issues for the efficient and economical delivery of quality pharmacy services to Enrollees. This collaborative meeting of pharmacy directors shall be referred to as the Kentucky Medicaid Pharmacy Director Workgroup. Meetings of this workgroup may be held separately or in combination with the medical director's or uniform pharmacy policy workgroup meetings in order to satisfy the monthly requirement.

All Department and Contractor Pharmacy Directors shall be committed to developing, contributing and fully supporting or enhancing collaborative projects or initiatives of the Department, such as, but not limited to, a Contractor process and quality review dashboard, a total (FFS and Contractor combined) pharmacy dashboard, universal criteria for specific drug products or classes, universal PA forms and other Department efforts. Any and all approved universal criteria, PA forms, or other materials produced by the Pharmacy Director Workgroup shall be utilized and accepted by all Contractors and the Department. Nothing herein shall be construed to give any approved universal PA form exclusivity, or otherwise negate applicable specialty or similar PA forms that may also be utilized by a Contractor. Contractor shall permit a Provider to submit an appropriate Kentucky Medicaid universal PA form or the applicable Contractor form to initiate a drug product PA consideration.

32.20 Pharmacy Information Materials & Document Approval

The Contractor shall submit, for the purpose of obtaining Department approval, all written materials in accordance with Sections 4.4, 23.5, and 28.4 of this Contract. Any materials or communications conveying pharmacy related information to the Enrollee or Provider (both pharmacy and prescriber) shall be subject to these requirements. However, Sections 4.4, 23.5 or 28.4 shall not include or cause to be included any specific drug or drug class therapeutic clinical

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criteria or PDL changes made in the normal conduct of the Contractor's P&T decisions so long as the materials are posted when required and in accordance with the requirements of Section 32 of this Contract or as otherwise directed by the Department.

32.21 Pharmacy Contract and Fee Approval

The Department shall review any subcontract including but not limited to, any contract between the Contractor and a pharmacy benefit manager or administrator or any entity contracted to perform such services in whole or in part entered into or renewed on or after the effective date of this Contract in accordance with Section 6.2.

Any fee established, modified, or implemented directly or indirectly by a managed care organization, pharmacy benefit manager or administrator, or entity which contracts on behalf of a pharmacy that is directly or indirectly charged to, passed onto, or required to be paid by a pharmacy services administration organization, group buying organization or the like, pharmacy, or Medicaid recipient shall be submitted to the Department for approval. This paragraph shall not apply to any membership fee or service fee established, modified, or implemented by a pharmacy services administration organization, group buying organization, or the like on a pharmacy licensed in Kentucky that is not directly or indirectly related to product reimbursement.

Any contract entered into or renewed by Contractor for the delivery in whole or part of Medicaid pharmacy services on or after the effective date of this Contract shall comply with all laws and administrative regulations promulgated by the Department, or other applicable regulatory authority, including but not limited to the regulation of maximum allowable costs programs.

32.22 Pharmacy Benefit Manager or Administrator Reporting Requirements

The Contractor shall comply with all pharmacy benefit reporting requirements of this Contract, the Department and those set forth by applicable statutory or regulatory authority. If the Contractor subcontracts any part of its pharmacy benefit administration to a pharmacy benefit manager or administrator or the like then the Contractor shall ensure and be held responsible for such contracted entity's failure or non-compliance with any pharmacy benefit reporting requirements set forth by this Contract, the Department or applicable regulatory authority.

The Contractor shall deliver or cause to be delivered through its agent or contracted entity to the Department no later than August 15, 2018, and for each contracting year thereafter, the following pharmacy benefit information:

A. The total Medicaid dollars paid to the pharmacy benefit manager by a managed care organization.
B. The total amount of Medicaid dollars paid to the pharmacy benefit manager by a managed care organization which were not subsequently paid to a pharmacy licensed in Kentucky.
C. The average reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefit manager to licensed pharmacies with which the pharmacy benefit manager shares common ownership, management, or control; or which are owned, managed, or controlled by any of the pharmacy benefit manager's management companies, parent companies, subsidiary companies jointly held companies, or companies otherwise affiliated by a common owner, manager, or holding company; or which share any common Enrollees on the board of directors; or which share managers in common.
D. The average reimbursement, by drug ingredient cost, dispensing fee, and any other fee, paid by a pharmacy benefit manager to pharmacies licensed in Kentucky which operate more than ten (10) locations.
E. The average reimbursement by drug ingredient cost, dispensing fee, and any other fee, paid by a pharmacy benefit manager to pharmacies licensed in Kentucky which operate ten (10)

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or fewer locations.

F. Any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in Kentucky with which the pharmacy benefit manager shares common ownership, management, or control; or which are owned, managed, or controlled by any of the pharmacy benefit manager's management companies, parent companies, subsidiary companies, jointly held companies, or companies otherwise affiliated by a common owner, manager, or holding company; or which share any common Enrollees on the board of directors; or which share managers in common.
G. Any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in Kentucky which operate more than ten (10) locations.
H. Any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in Kentucky which operate ten (10) or fewer locations.
I. All common ownership, management, common Enrollees of a board of directors, shared managers, or control of a pharmacy benefit manager, or any of the pharmacy benefit manager's management companies, parent companies, subsidiary companies, jointly held companies, or companies otherwise affiliated by a common owner, manager, or holding company with any managed care organization contracted to administer Kentucky Medicaid benefits, any entity which contracts on behalf of a pharmacy, or any pharmacy services administration organization, or any common ownership, management, common Enrollees of a board of directors, shared managers, or control of a pharmacy services administration organization that is contracted with a pharmacy benefit manager, with any drug wholesaler or distributor or any of the pharmacy services administration organizations, management companies, parent companies, subsidiary companies, jointly held companies, or companies otherwise affiliated by a common owner, common Enrollees of a board of directors, manager, or holding company.

All information provided by the Contractor or its agent or contracted entity shall reflect data for the most recent full calendar year and shall be divided by calendar months pursuant to the reporting template format approved and directed by the Department. This reporting template may be revised by the Department without additional notice to the Contractor so long as delivery of the revised template is made sixty (60) days prior to the next reporting delivery date.

33.0 Special Program Requirements

33.1 EPSDT Early and Periodic Screening, Diagnosis and Treatment

The Contractor shall provide all Enrollees under the age of twenty-one (21) years, except those eligible pursuant to 907 KAR 4:030, EPSDT services in compliance with the terms of this Contract and policy statements issued during the term of this Contract by the Department or CMS. The Contractor shall file EPSDT reports in the format and within the time-frames required by the terms of this Contract as indicated in **Appendix M. "EPSDT."** The Contractor shall comply with 907 KAR 11:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program. Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:

A. Provide, through direct employment with the Contractor or by Subcontract, accessible and fully trained EPSDT Providers who meet the requirements set forth under 907 KAR 1:034, and who are supported by adequately equipped offices to perform EPSDT services.
B. Effectively communicate information (e.g. written notices, verbal explanations, face to face counseling or home visits when appropriate or necessary) with Enrollees and their families who are eligible for EPSDT services [(i.e. Medicaid eligible persons who are under the age of twenty-one (21)] regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these services, and the Enrollee's right to access these

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services. Enrollees and their families shall be informed about EPSDT and the right to Appeal any decision relating to Medicaid services, including EPSDT services, upon initial enrollment and annually thereafter where Enrollees have not accessed services during the year.

C. Provide EPSDT services to all eligible Enrollees in accordance with EPSDT guidelines issued by the Commonwealth and federal government and in conformance with the Department's approved periodicity schedule, a sample of which is included in Appendix M. "EPSDT."
D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034. The Primary Care Provider assigned to each eligible Enrollee shall be responsible for providing or arranging for complete assessments at the intervals specified by the Department's approved periodicity schedule and at other times when Medically Necessary.
E. Provide all needed diagnosis and treatment for eligible Enrollees in accordance with 907 KAR 1:034. The Primary Care Provider and other Providers in the Contractor's Network shall provide diagnosis and treatment and or Out-of-network Providers shall provide treatment if the service is not available within the Contractor's network.
F. Provide EPSDT Special Services for eligible Enrollees, including identifying providers who can deliver the Medically Necessary services described in federal Medicaid law and developing procedures for authorization and payment for these services. Current requirements for EPSDT Special Services are included in Appendix M. "EPSDT."
G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible Enrollees are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.
H. Establish and maintain an effective and on-going Enrollee Services case management function for eligible Enrollees and their families to provide education and counseling with regard to Enrollee compliance with prescribed treatment programs and compliance with EPSDT appointments. This function shall assist eligible Enrollees or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Enrollees and their families when recommended assessments and treatment are not received.
I. Maintain a consolidated record for each eligible Enrollee, including reports of informing about EPSDT, information received from other providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and reports from referral physicians or providers.
J. Establish and maintain a protocol for coordination of physical health services and Behavioral Health Services for eligible Enrollees with behavioral health or developmentally disabling conditions. Coordination procedures shall be established for other services needed by eligible Enrollees that are outside the usual scope of Contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's individual education plan at school, WIC, Head Start, DCBS, etc.
K. Participate in any state or federally required chart audit or quality assurance study.
L. Maintain an effective education/information program for health professionals on EPSDT compliance (including changes in state or federal requirements or guidelines). At a minimum, training shall be provided concerning the components of an EPSDT assessment, EPSDT Special Services, and emerging health status issues among Enrollees which should be addressed as part of EPSDT services to all appropriate staff and Providers, including medical residents and specialists delivering EPSDT services. In addition, training shall be provided concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services.
M. Submit Encounter Record for each EPSDT service provided according to requirements provided by the Department, including use of specified EPSDT procedure codes and referral

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codes. Submit quarterly and annual reports on EPSDT services including the current Form CMS-416.

N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.

33.2 Dental Services

Except as provided in Section 42 of this contract, the Contractor shall provide preventive and primary care dental services for oral health conditions and illness in a timely manner on an emergent, urgent care or non-urgent care basis in accordance with 42 C.F.R. 438. Covered dental services shall be provided in accordance with 907 KAR 1:026.

The Contractor shall enroll providers of dental services in accordance with KRS 304.17A-270, and establish written policies and procedures to ensure the timely provision of services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services provided to fee-for-service Medicaid Enrollees. The Contractor shall assess the oral health of Enrollees and develop a plan for improving oral health in Enrollees, particularly in children and persons with special health care needs.

The Contractor shall have ultimate responsibility for the provision of dental services and shall oversee and coordinate the delivery of or access to all Enrollee health information and other data relating to dental services, as requested by the Department.

The Contractor will also provide for adherence to standards of care based on established clinical criteria and evidence based science.

The Contractor shall determine the Medical Necessity criteria to be used in the provision of dental services which shall be submitted to the Department for approval in accordance with Section 4.4, "**Approval of Department**."

33.3 Emergency Care, Urgent Care and Post Stabilization Care

Emergency Care as defined in 42 USC 1395dd and 42 C.F.R. 438.114 shall be available to Enrollees twenty-four (24) hours a day, seven (7) days a week. Urgent Care services shall be made available within forty-eight (48) hours of request. Urgent Care means care for a condition that is not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment. Post Stabilization Care services are covered and reimbursed in accordance with 42 C.F.R. 422.113(c) and 438.114(e).

The Contractor shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. An Emergency Medical Services Provider shall have a minimum of ten (10) calendar days to notify the Contractor of the Enrollee's screening and treatment before refusing to cover the emergency services based on a failure to notify. An Enrollee who has an emergency medical condition shall not be liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. The Contractor is responsible for coverage and payment of services until the attending Provider determines that the Enrollee is sufficiently stabilized for transfer or discharge.

33.4 Out-of-Network Emergency Care

The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's network in compliance with 42 C.F.R. 438.114.

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Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid Fee-For-Service rate as required by Section 6085 of the Deficit Reduction Act of 2005. For services provided by non-contracting hospitals, this amount must be less any payments for indirect costs of medical education and direct costs of graduate medical education that would have been included in Fee-For-Service payments.

33.5 Maternity Care

When a woman has entered prenatal care before enrolling with the Contractor shall take every effort to allow her to continue with the same prenatal care provider throughout the entire pregnancy. Contractor shall also establish procedures to assure either prompt initiation of prenatal care or continuation of care without interruption for women who are pregnant when they enroll. The Contractor shall provide maternity care that includes prenatal, delivery, and postpartum care as well as care for conditions that complicate pregnancies. All newborn Enrollees shall be screened for those disorders specified in the Commonwealth of Kentucky metabolic screen.

33.6 Voluntary Family Planning

The Contractor shall ensure direct access for any Enrollee to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are described in **Appendix H. "Covered Services"** to this Contract. The Contractor may not restrict an eErollee's choice of his or her provider for Family Planning Services. Contractor must assure access to any qualified provider of Family Planning Services without requiring a referral from the PCP.

The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Enrollees less than eighteen (18) years of age pursuant to Title X. 42 C.F.R. 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et seq., KRS 202A, and KRS 214.185.

All information shall be provided to the Enrollee in a confidential manner. Appointments for counseling and medical services shall be available as soon as possible with in a maximum of thirty (30) days. If it is not possible to provide complete medical services to Enrollees less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within ten (10) days. Adolescents in particular shall be assured that Family Planning Services are confidential and that any necessary follow-up will assure the Enrollee's privacy.

33.7 Nonemergency Medical Transportation

The Department contracts with the Office of Transportation and Delivery to provide non-emergency medical transportation (NEMT) services to select Medicaid Enrollees. Through the NEMT program, certain eligible Enrollees receive safe and reliable transportation to Medicaid covered services. The Department shall continue to provide NEMT services for Medicaid Enrollees except as provided in Section 42. The Contractor shall provide educational materials regarding the availability of transportation services and refer Enrollees for NEMT. NEMT services do not include emergency ambulance and non-emergency ambulance stretcher services. Transportation of an emergency nature, including ambulance stretcher services is the responsibility of the Contractor.

33.8 Pediatric Interface

School-Based Services provided by school personnel are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid.

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Preventive and remedial care services as contained in 907 KAR 1:360 and the Kentucky State Medicaid Plan provided by the Department of Public Health through public health departments in schools by a Physician, Physician's Assistant, Advanced Registered Nurse Practitioner, Registered Nurse, or other appropriately supervised health care professional are included in Contractor coverage. Service provided under a child's IEP should not be duplicated. However, in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services to eligible Enrollees.

Services provided under HANDS shall be excluded from Contractor coverage.

Pediatric Interface Services includes pediatric concurrent care as mandated by the ACA. The Contractor shall simultaneously provide palliative hospice services in conjunction with curative services and medications for pediatric patients diagnosed with life-threatening/terminal illnesses.

33.9 Pediatric Sexual Abuse Examination

Contractor shall have Providers in its network that has the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Enrollees at the request of the DCBS.

33.10 Lock-In Program

The Contractor shall develop a program to address and contain Enrollee over utilization of services, for pharmacy and non-emergent care provided in an emergency setting. The criteria for this program shall be submitted to the Department for approval subject to Section 4.4 "**Approval of Department**."

34.0 Behavioral Health Services

34.1 Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) Responsibilities

The Department works collaboratively with Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to assure that Medicaid Enrollees receive quality behavioral health services.

The Contractor shall use evidence-based practices (EBPs) that meet the standards of national models in all behavior health services. The Contractor shall comply with standards identified in the "Interoperability Standards Advisory—Best Available Standards and Implementation Specifications" (ISA) and 45 CFR 170 Subpart B in complying with the Commonwealth's behavioral health policies.

34.2 Requirements for Behavioral Health Services

The Contractor shall engage in behavioral health promotion efforts, psychotropic medication management, suicide prevention and overall person centered treatment approaches, to lower morbidity among Enrollees with SMI and SED, including Enrollees with co-occurring developmental disabilities, substance use disorders and smoking cessation.

The Contractor in its design and operation of behavioral health services shall incorporate these core values for Medicaid Enrollees:

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A. Enrollees have the right to retain the fullest control possible over their behavior health treatment. Behavioral health services shall be responsive, coherently organized, and accessible to those who require behavioral healthcare.
B. The Contractor shall provide the most normative care in the least restrictive setting and serve Enrollees in the community to the greatest extent possible.
C. The Contractor shall measure Enrollees' satisfaction with the services they receive.
D. The Contractor's behavioral health services shall be recovery and resiliency focused.

34.3 Covered Behavioral Health Services

The Contractor shall assure the provision of all Medically Necessary Behavioral Health Services for Enrollees. These services are described in **Appendix H. "Covered Services."** All Behavioral Health services shall be provided in conformance with the access standards established by the Department. When assessing Enrollees for Behavioral Health Services, the Contractor and its providers shall use the most current version of DSM classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of DMS. Providers shall document DSM diagnosis and assessment/outcome information in the Enrollee's medical record.

34.4 Behavioral Health Provider Network

The Contractor shall provide access to Psychiatrists, Psychologists, and other behavioral health service providers. Community Mental Health Centers (CMHCs) shall be offered participation in the Contractor provider network. Other eligible providers of behavioral health services include Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Behavior Health Services Organizations, Licensed Clinical Social Workers, and other independently licensed behavioral health professions. To the extent that non-psychiatrists and other providers of Behavioral Health services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.

34.5 Enrollee Access to Behavioral Health Services

The Contractor shall ensure accessibility and availability of qualified providers to all Enrollees. The Contractor shall maintain an adequate network that provides continuum of care to ensure the Enrollee has access to care at the appropriate level. The Contractor shall ensure that upon decertifying an Enrollee at a certain level of care, there is access to Providers for continued care at a lower level, if such care is determined medically necessary. The Contractor shall coordinate and collaborate with Providers on discharge plans and criteria.

The Contractor shall maintain an Enrollee education process to help Enrollees know where and how to obtain Behavioral Health Services. The Enrollee Manual shall contain information for Enrollees on how to direct their behavioral health care, as appropriate.

The Contractor shall permit Enrollees to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall provide the Enrollee with information on accessible in-network Providers with relevant experience.

34.6 Behavioral Health Services Hotline

The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Commonwealth. Crisis hotline staff must include or

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have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies. Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face to face emergency services shall be available twenty-four (24) hours a day, seven (7) days a week. The Behavioral Health Services Hotline shall not be answered by any automated means.

The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following **minimum** performance requirements for all Contractor Programs:

A. Ninety-nine percent (99%) of call are answered by the fourth ring;
B. No incoming calls receive a busy signal;
C. The call abandonment rate is seven percent (7%) or less; and
D. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 emergency services.

The Contractor shall operate one hotline to handle emergency and crisis calls. The Contractor cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Enrollee. Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Enrollees, including the interpretive services required for effective communication.

The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs.

The Contractor shall conduct ongoing quality assurance to ensure these standards are met.

The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.

If the Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractor is responsible for all reasonable costs incurred by the Department or its authorized agent(s) relating to such monitoring.

34.7 Coordination between the Behavioral Health Provider and the PCP

The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice. Such contract provisions and screening and evaluation procedures shall be submitted to the Department for approval. Such approval is subject to Section 4.4 "**Approval of Department**."

The Contractor shall provide training to network PCPs on how to screen for and identify behavioral health disorders, the Contractor's referral process for Behavioral Health Services and clinical coordination requirements for such services. The Contractor shall include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.

The Contractor shall develop policies and procedures and provide to the Department for approval regarding clinical coordination between Behavioral Health Service Providers and PCPs. Such approval is subject to Section 4.4 "**Approval of Department**." The Contractor shall require that Behavioral Health Service Providers refer Enrollees with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the

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Enrollee's or the Enrollee's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals.

The Contractor shall require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of an Enrollees' behavioral health status to the PCP, with the Enrollee's or the Enrollee's legal guardian's consent. This requirement shall be specified in all Provider Manuals.

34.8 Follow-up after Hospitalization for Behavioral Health Services

The Contractor shall require, through Provider contract provision, that all Enrollees receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. The Contractor shall ensure that Behavioral Health Service Providers contact Enrollees who have missed an appointment within twenty-four (24) hours to reschedule appointments.

34.9 Court-Ordered Services

“Court-Ordered Commitment” means an involuntary commitment of an Enrollee to a psychiatric facility for treatment that is ordered by a court of law pursuant to Kentucky statutes.

The Contractor must provide inpatient psychiatric services to Enrollees under the age of twenty-one (21) and over the age of sixty-five (65) who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.

The Contractor cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court ordered commitment for Enrollees under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

34.10 Continuity of Care Upon Discharge from a Psychiatric Hospital

A. The Contractor shall coordinate with providers of behavioral health services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Enrollees committed by a court of law and/or voluntarily admitted to the state psychiatric hospital. The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their Medicaid Region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law. At a minimum the agreement shall include responsibilities of the Behavioral Health Service Provider to assure continuity of care for successful transition back into community-based supports. In addition, the Contractor Behavioral Health Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.
B. The Contractor shall ensure Behavioral Health Service Providers assign a case manager prior to or on the date of discharge and provide basic, targeted or intensive case management services as medically necessary to Enrollees with SMI and co-occurring conditions who are discharged from a state operated or state contracted psychiatric facility or state operated nursing facility for Enrollees with SMI. The Case Manager and other identified behavioral health service providers shall participate in discharge planning

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meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Enrollee's behavioral and physical health needs, including psychosocial rehabilitation and health promotion. Appropriate follow up by the Behavioral Health Service Provider shall occur to ensure the community supports are meeting the needs of the Enrollee discharged from a state operated or state contracted psychiatric hospital. The Contractor shall ensure the Behavioral Health Service Providers assist Enrollees in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.

34.11 Program and Standards

Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage are especially important when Enrollees use physical and behavioral health systems simultaneously. The Contractor shall:

A. Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective physical and behavioral health care, including emergency behavioral health services, (i.e. Suicide Prevention and community crisis stabilization);
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;
C. Identify a method to evaluate the continuity and coordination of care, including Enrollee-approved communications between behavioral health care providers and primary care providers;
D. Protect the confidentiality of Enrollee information and records; and
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.

The Department shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological medications shall be closely monitored. The findings of these evaluations will be provided to the Contractor.

34.12 NCQA/MBHO Accreditation Requirements

The Contractor shall demonstrate to the Department its compliance with NCQA/MBHO accreditation requirements by meeting the following standards:

A. The availability of behavioral healthcare practitioners and providers within its network;
B. The development of preventive behavioral health programs;
C. The development of Self-Management Tools for Use by Enrollees;
D. The establishment of a Complex Case Management Program that addresses the needs of adults with SMI, children with SED and other high risk groups with co-occurring conditions;
E. The adoption of Clinical Practice Guidelines specific to the needs of behavioral health clients;
F. The establishment of a process for Data Collection and Integration between the Contractor and the MBHO;
G. Identify and report on critical Performance Measures that are specific to behavioral health Enrollees;
H. Establish a written program description for the MBHO's Utilization Management Program;
I. Establish a process for collaboration between behavioral healthcare and medical care.

34.13 Coordination and Collaboration with Behavioral Health Providers

The Contractor shall identify and develop community alternatives to inpatient hospitalization for

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those Enrollees who are currently receiving inpatient psychiatric facility services and could be discharged from the facility if an appropriate treatment alternative were made available in the community. In the event that the Contractor does not provide and cover an appropriate community alternative, the Contractor shall remain financially responsible for the continued inpatient care of these individuals until the Contractor ensures availability and access to an appropriate community provider.

35.0 Case Management

35.1 Health Risk Assessment (HRA)

The Contractor shall have programs and processes in place to address the preventive and chronic physical and behavioral health care needs of its population. The Contractor shall implement processes to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the ongoing special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.

The Contractor shall conduct initial health screening assessments, including mental health and substance use disorders screenings, of new Enrollees who have not been enrolled with the Contractor in the prior twelve (12) month period for the purpose, of accessing the Enrollees' health care needs within ninety (90) days of Enrollment. If the Contractor has a reasonable belief an Enrollee is pregnant, the Enrollee shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care. The Contractor agrees to make all reasonable efforts to contact new Enrollees in person, by telephone, or by mail to have Enrollees complete the initial health screening questionnaire which includes the survey instrument for both substance use and mental disorders. Reasonable effort is defined as at least three attempts to contact the Enrollee with at least one of those attempts by phone. The three attempts by the Contractor may not be within the same day.

Information to be collected shall include demographic information, current health and behavioral health status to determine the Enrollee's need for care management, disease management, behavioral health services and/or any other health or community services.

The Contractor shall use appropriate health care professionals in the assessment process. Enrollees shall be offered assistance in arranging an initial visit to their PCP for a baseline medical assessment and other preventive services, including an assessment or screening of the Enrollees potential risk, if any, for specific diseases or conditions including substance use and mental health disorders.

The Contractor shall submit a quarterly report on the number of new Enrollee assessments; number of assessments completed; number of assessments not completed after reasonable effort; and number of refusals.

The Contractor shall, upon request, share with the Department or another MCO, if the Enrollee is assigned to the MCO, the result of any identification and assessment of the Enrollee's needs to prevent duplication.

The Contractor shall be responsible for the management and continuity of health care for all Enrollees.

The Contractor shall utilize the common HRA, as designated by the Department.

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35.2 Care Management System

As part of the Care Management System, the Contractor shall employ care coordinators and case managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to an Enrollee. Enrollees needing Care Management Services shall be identified through the health risk assessment, evaluation of Claims data, Physician referral or other mechanisms that may be utilized by the Contractor. The Contractor shall develop guidelines for Care Coordination that will be submitted to the Department for review and approval. The Contractor shall have approval from the Department for any subsequent changes prior to implementation of such changes subject to Section 4.4 "**Approval of Department**." Care coordination shall be linked to other Contractor systems, such as QI, Enrollee Services and Grievances.

35.3 Care Coordination

The care coordinators and case managers will work with the primary care providers as teams to provide appropriate services for Enrollees. Care coordination is a process to assure that the physical and behavioral health needs of Enrollees are identified and services are facilitated and coordinated with all service providers, individual Enrollees and family, if appropriate, and authorized by the Enrollee. The Contractor shall identify the primary elements for care coordination and submit the plan to the Department for approval.

The Contractor shall identify an Enrollee with special physical and behavioral health care needs and shall have a Comprehensive Assessment completed upon admission to a Care Management program. The Enrollee will be referred to Care Management. Guidelines for referral to the appropriate care management programs shall be pre-approved by the Department. The guidelines will also include the criteria for development of Care Plans. The Care Plan shall include both appropriate medical, behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan and medical diagnosis.

The Contractor shall first complete a Care Coordination Assessment for these Enrollees the elements of which shall comply with policies and procedures approved by the Department.

The Care Plan shall be developed in accordance with 42 C.F.R. 438.208.

The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all DCBS clients. The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and services specific to the DCBS population.

Enrollees, Enrollee representatives and providers shall be provided information relating to care management services, including case management, and information on how to request and obtain these services.

All approvals required by this section are subject to Section 4.4 "**Approval of Department**."

35.4 Coordination with Women, Infants and Children (WIC)

The Contractor shall comply with Section 1902(a)(11)(C) of the Social Security Act which requires coordination between Medicaid MCOs and WIC. This coordination includes the referral of potentially eligible women, infants and children to the WIC program and the provision of medical information by providers working within Medicaid managed care plans to the WIC program if requested by WIC agencies and if permitted by applicable law. Typical types of medical

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information requested by WIC agencies include information on nutrition-related metabolic disease, diabetes, low birth weight, failure to thrive, prematurity, infants of alcoholics, mentally retarded or drug-addicted mothers, AIDS, allergy or intolerance that affects nutritional status and anemia.

36.0 Enrollees with Special Health Care Needs

36.1 Individuals with Special Health Care Needs (ISHCN)

Individuals with Special Health Care Needs (ISHCN) are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.

As per the requirement of 42 C.F.R. 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how Enrollees with these multiple and complex physical and behavioral health care needs are further identified. The Contractor shall have an internal operational process, in accordance with policy and procedure, to target Enrollees for the purpose of screening and identifying ISHCN's. The Contractor shall assess each enrollee identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals. The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations:

A. Children in/or receiving Foster Care or adoption assistance;
B. Blind/Disabled Children under age 19 and Related Populations eligible for SSI;
C. Adults over the age of 65;
D. Homeless (upon identification);
E. Individuals with chronic physical health illnesses;
F. Individuals with chronic behavioral health illnesses;
G. Children receiving EPSDT Special Services;
H. Children receiving services in a Pediatric Prescribed Extended Care facility or unit.

The Contractor shall develop and distribute to ISHCN Enrollees caregivers, parents and/or legal guardians, information and materials specific to the needs of the Enrollee, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and /or caregivers in understanding their chronic illness.

The contractor shall have in place policies governing the mechanisms utilized to identify, screen and assess individuals with special health care needs. The Contractor will produce a treatment plan for Enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.

The Contractor shall develop practice guidelines and other criteria that consider that needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population.

36.2 DCBS and DAIL Protection and Permanency Clients

Enrollees who are adult guardianship clients or foster care children shall be identified as ISHCN. The Contractor shall attempt to obtain the service plan which will be completed by DCBS or DAIL.

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The service plan will be used by DCBS and/or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these Enrollees whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care and Adult Guardianship Cases shall be sent to Department thirty (30) days after the end of each month.

The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all DCBS and DAIL clients. The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and services specific to the DCBS and DAIL population.

36.3 Adult Guardianship Clients

Each adult in Guardianship shall have a service plan prepared by DAIL. The service plan shall indicate DAIL level of responsibility for making medical decisions for each Enrollee. If the service plan identifies the need for case management, the Contractor shall work with Guardianship staff and/or the Enrollee, as appropriate, to determine what level of case management is needed.

36.4 Children in Foster Care

No less than quarterly, Contractor's staff shall meet with DCBS staff to identify, discuss and resolve any health care issues and needs of the Contractor's Foster Care Membership. Examples of these issues include needed specialized Medicaid Covered Services, community services and whether the child's current primary and specialty care providers are enrolled in the Contractor's Network.

If the DCBS service plan identifies the need for case management or DCBS staff requests case management for an Enrollee, the Contractor's staff will work with foster parent and/or DCBS staff to develop a case management plan.

The Contractor's staff will consult with DCBS staff before the development of a new case management plan (on a newly identified health care issue) or modification of an existing case management plan.

The designated Contractor staff will sign each service plan made available by DCBS to indicate their agreement with the plan. If the DCBS and Contractor staff cannot reach agreement on the service plan for an Enrollee, information about that Enrollee's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and Contractor staff will be forwarded to the designated Department representative.

The Contractor shall notify the Department and DCBS no later than three (3) business days <u>prior</u> to the decertification of a foster child for services at a hospital or other residential facility located in Kentucky and no later than seven (7) business days <u>prior</u> to the decertification of a foster child for services at a hospital or other residential facility located out of state. Written documentation of an upcoming medical necessity review does not qualify as a decertification notification. The Department shall provide the Contractor with the office or division, the individual(s) and the contact information for such notification and provide updated contact information as necessary. The decertification notification shall include the Enrollee name, Enrollee ID, facility name, level of care, discharge plan and date of next follow-up appointment. If the Contractor fails to notify the Department and DCBS at least three (3) business days or seven (7) business days, as applicable, prior to the decertification and the foster child remains in the facility because arrangements for placement cannot be made, the Contractor shall be responsible for the time the

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foster child remains in the facility prior to notification and up to three (3) business days or seven (7) business days, as applicable, after notification.

The Contractor shall not decertify any child in foster care, for services at a hospital or other residential facility, without a documented peer to peer between the DMS, DCBS, or DBHDID Medical Director and the Contractor's physician who is making the decision to decertify. A peer to peer is not required if DCBS agrees with the decertification or discharge.

The Contractor shall require in its contracts with Providers that the Provider provides basic, targeted or intensive case management services as medically necessary to foster children who are discharged from a hospital or other residential facility. The Contractor, case manager and Provider shall participate in appropriate discharge planning, focused on ensuring that the needed supports and services to meet the Enrollee's behavioral and physical health needs will be provided outside of the hospital or other residential facility.

36.5 Legal Guardians

The Contractor shall permit a parent, custodial parent, person exercising custodial control or supervision, or an agency with legal responsibility for a child by virtue of voluntary commitment or emergency or temporary custody orders to act on behalf of an Enrollee under the age of eighteen (18), potential Enrollee or former Enrollee for purposes of selecting a PCP, filing Grievances or Appeals, and otherwise acting on behalf of the child in interactions with the Contractor.

A legal guardian of an adult Enrollee appointed pursuant to KRS 387.500 to 387.800 shall be allowed to act on behalf of a ward as defined in that statute, and a person authorized to make health care decisions pursuant to KRS 311.621, et seq. shall be allowed to act on behalf of an Enrollee, prospective Enrollee or former Enrollee. an Enrollee may represent her/himself, or use legal counsel, a relative, a friend, or other spokesperson.

36.6 Enrollees with SMI Residing in Institutions or At Risk of Institutionalization

The Contractor shall participate in transition planning and continued care coordination for Enrollees with SMI who are transitioning from licensed Personal Care Homes, psychiatric hospitals, or other institutional settings to integrated, community based housing. The Contractor shall perform a comprehensive physical and behavioral health assessment designed to support the successful transition to community based housing within fourteen (14) days of the transition. To perform such assessment, the Contractor shall review the Enrollee's Person-Centered Recovery Plan and level of care determination developed by the provider agency in tandem with Contractor's routine UM procedures. The Contractor shall provide services that are recommended in the Person-Centered Recovery Plan and that meet medical necessity criteria.

37.0 Program Integrity

The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 C.F.R. 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements. The Contractor shall have sufficient investigatory capacity necessary to comply with all applicable requirements and standards under the contract as well as all federal and state requirements and standards to detect fraud, waste and abuse. The Department has defined minimums standards for the Contractor's Program Integrity Unit (PIU) as follows:

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A. Identification of a minimum of 2% in provider overpayments and prepayment cost avoidance on Report 64;
B. Conducting a minimum of three (3) on-site visits per quarter;
C. Attending any training or meeting given by the Commonwealth;
D. Collecting outstanding debt owed to the Department;
E. Respond to informational or reporting requests timely;
F. Requesting permission to administratively collect overpayments in excess of $500;
G. Ensuring formal case tracking and case management of provider and member cases;
H. Maintain two (2) full-time investigators with a minimum of three (3) years Medicaid fraud, waste and abuse investigatory experience located in Kentucky dedicated 100% to the Kentucky Medicaid Program, and notification to the Department's Program Integrity Director if there is any absence or vacancy that is more than thirty (30) days with a contingency plan to remain compliant with the other contract requirements in the interim; and
I. Meeting the requirements of Appendix N.

37.1 Program Integrity Plan

The Contractor shall develop in accordance with the Contract requirements in this Section and **Appendix N. "Program Integrity Requirements**," a Program Integrity plan for the Commonwealth of Kentucky of internal controls and policies and procedures for preventing, identifying and investigating Enrollee and provider fraud, waste and abuse. If the Department changes its program integrity activities, the Contractor shall have up to three (3) months to provide a new or revised program. This plan shall include, at a minimum:

A. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the contract as well as all federal and state requirements and standards;
B. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the Board of Directors;
C. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements under this Contract;
D. Effective training and education for the Contractor's Compliance Officer, senior management, employees, subcontractors, providers, and Enrollees for the federal and state standards and requirements under the contract, including:
    1. Training and education regarding fraud, waste, and abuse; and
    2. Detailed information about the False Claims Act (FCA), rights of employees to be protected as whistleblowers, and other federal and state laws described in Section 1902 of the Act (42 USC 1396a(a)(68));
E. Effective lines of communication between the Compliance Officer and the Contractor's employees;
F. Enforcement of standards through written and well-publicized disciplinary guidelines;
G. Written procedures and an operational system that include but are not limited to the following:
    1. Routine internal monitoring and auditing of Enrollee, provider and compliance risks by dedicated staff for the Contractor and any Subcontractor;
    2. Prompt investigation, response and development of corrective action initiatives to compliance risks or issues as they are raised or identified in the course of self-evaluation or audit, including coordination with law enforcement agencies for suspected criminal acts, to reduce potential recurrence and ensure ongoing compliance under the contract;
    3. Provision for immediate notification to the Department's Program Quality & Outcomes Division Director and Program Integrity Division Director should any employee of the

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Contractor, Subcontractors or agents seek protection under the False Claims Act;

4. Provision for prompt reporting to the Department of all overpayments identified or recovered, specifying the overpayments due to potential fraud, in a manner as determined by the Department;
5. Prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the Department's program integrity unit or any potential fraud directly to the state Medicaid Fraud Control Unit in the form of an investigative report or in another manner as prescribed by the Department;
6. Provision for network providers to report and return to the Contractor any overpayment within sixty (60) calendar days of identification, and to notify Contractor in writing of the reason for the overpayment;
7. Suspension and escrow of payments to a network provider for which the Department has notified the Contractor that there is a credible allegation of fraud in accordance with 42 C.F.R. 455.23 and report payment suspension information quarterly in a manner determined by the Department;
8. Prompt notification to the Department when it receives information about a change in an Enrollee's circumstances that may affect the Enrollee's eligibility including changes in the Enrollee's residence or the death of the Enrollee;
9. Notification to the Department when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor;
10. Method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers have been delivered to Enrollees and the application of such verification processes on a regular basis;
11. Ensure all of Contractor's network providers are enrolled with the Department consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. 455;
12. An accounts receivable process to collect outstanding debt from Enrollees or providers and provide monthly reports of activities and collections to the Department in a manner determined by the Department;
13. An appeal process;
14. Process for card sharing cases;
15. Tracking the disposition of all Enrollee and provider cases (initial and preliminary) as well as case management that allows for ad hoc reporting or case status
16. A prepayment review process in accordance with this contract; and

H. Contractor shall be subject to on-site review; and comply with requests from the Department to supply documentation and records;

I. Contractor shall comply with the expectations of 42 C.F.R. 455.20 by employing a method of verifying with Enrollee whether the services billed by provider were received by randomly selecting a minimum sample of five hundred (500) Claims on a monthly basis;

J. Contractor shall 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 identified and collected;

K. Contractor shall follow cases from the time they are opened until they are closed following written protocol regarding submission of investigative reports to the Department;

L. Contractor shall notify Department within fifteen (15) business days in a manner determined by the Department of any provider placed on prepayment review related to fraud, waste and abuse. The information shall include at a minimum the following:

1. Case Number;
2. Provider Name;
3. Medicaid Provider ID;
4. NPI;
5. Summary of Concern; and
6. Date action taken.

The Contractor shall submit an annual listing of providers that were under prepayment

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review during the state fiscal year in a manner determined by the Department; and

M. Contractor shall attend any training given by the Commonwealth, Department, its Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.

The plan shall be made available to the Department for review and approval subject to Section 4.4 "**Approval of Department**."

37.2 Prepayment Review

The Contractor shall have written, policies, procedures and standards of conduct for a prepayment review process in accordance with the requirements of this contract, and should perform a review when there is a sustained or high level of payment error or data analysis identifies a problem area related to possible Fraud, Waste and Abuse. Any request for a prepayment review process outside of the scope of Fraud, Waste and Abuse as prescribed in this Section shall be submitted in writing to the Director of the Division of Program Qualify Outcomes for approval with copy to the Director of the Division of Program Integrity.

The Contractor shall have discretion on when to utilize prepayment review, but should consider such review due to a high volume of services, high cost, dramatic change in frequency of use, high risk problem-prone area, complaints, or if the Department or any other federal or state agency has identified a certain vulnerability in a service area. The Contractor shall not use prepayment review to hold claims for an indefinite period of time. The Contractor shall review the documentation submitted within a reasonable amount of time to determine whether the claim should be paid. Claims under prepayment review are not subject to prompt payment or timely filing requirements.

Notice shall be sent to the provider in writing on or before the date a prepayment review is started. The written notice shall contain the following:

A. Specific reason for the review;
B. Complete description of the specific documentation needed for the review and method of submission;
C. Timeframe for returning the documentation, and information that the claim will be denied if documentation is not returned timely;
D. Length of time the prepayment review will be conducted if the Contractor has determined one at its discretion;
E. Contact information if there are questions related to the prepayment review; and
F. Information on how the provider may request removal of a prepayment review.
G. Ensure the documentation is readily available in the investigative progression from referral (external or internal) to closure and ensure the investigation meets Departmental requirements as well as the requirements of case tracking, case management and reporting.

The Provider shall be given forty-five (45) calendar days to submit documents in support of claims under prepayment review. The Contractor shall deny claims for which the requested documentation was not received by day forty-six (46). The Contractor shall deny a claim when the submitted documentation lacks evidence to support the service or code. The Contractor shall follow Contract Provision 28.9 for any appeals related to the prepayment process. The Contractor may extend the length of a prepayment review when it is determined necessary to prevent improper payments. If the provider has sustained a ninety (90) percent error free claims submission rate to the Contractor for forty-five (45) calendar days the Contractor must request express permission to continue prepayment review from the Director of Program Integrity (or designee) and the Director of Program Quality and Outcomes (or designee).

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37.3 Report of Suspected Fraud, Waste or Abuse

If the Contractor fails to properly report a case of suspected provider fraud, waste or abuse to the Department before the suspected fraud, waste or abuse is identified by the Commonwealth, its designees, the United States or private parties acting on behalf of the United States, any portion of the funds related to fraud or abuse recovered by the Commonwealth or designees shall be retained by the Commonwealth or its designees.

37.4 Audit by Department or its Designee

If the Department performs or contracts with an entity that performs audits of claims paid by the Contractor and identifies an overpayment, then the Department shall send notice to the Contractor and collect and retain any overpayment. The Contractor shall remit the amount or balance of the provider overpayment within ninety (90) calendar days of notification by the Department unless otherwise notified in writing by the Department or contracted entity. The Contractor may request an extension of the remittance with justification to the Department's Program Integrity Director prior to the deadline. Failure to remit an amount within the timeframe will result in a $500.00 penalty per incident.

37.5 Contractor Dispute of Audit by Department or its Designee

The Contractor shall have thirty (30) calendar days to dispute an Overpayment identified by the Department, in writing to the Department's Program Integrity Director, or the Department's designee, within thirty (30) calendar days of receiving notice of the identified Overpayment. Failure of the Contractor to meet contractual, state or federal requirements will not be an acceptable basis for Overpayment disputes. The Department will have the sole discretion to uphold or overturn, or amend, an identified Overpayment disputed by the Contractor. The Contractor shall be notified of the decision of the Department in writing within ninety (90) calendar days of receipt.

38.0 Contractor Reporting Requirements

38.1 General Reporting and Data Requirements

The Contractor shall provide to the Department managerial, financial, delegation, utilization, quality, Program Integrity and enrollment reports in compliance with 42 C.F.R. 438.604. The parties acknowledge that CMS has requested the Department to provide certain reports concerning Contractor. Contractor agrees to provide Department with the reports CMS has requested or does request. Additionally, the parties agree for Contractor to provide any additional reports requested by Department. The parties agree that **Appendix K. "Reporting Requirements and Reporting Deliverables"** may be amended outside the scope of this agreement. The Department may require the Contractor to prepare and submit ad hoc reports. The Department must give the Contractor sufficient notice prior to the submission of ad hoc reports to the Department. The notice must be reasonable relative to the nature of the ad hoc report requested by the Department. At a minimum, the Department must give Contractor five (5) business days' notice prior to submission of an ad hoc report.

The Contractor shall respond to any Department request for information or documents within the timeframe specified by the Department in its request. If the Contractor is unable to respond within the specified timeframe, the Contractor shall immediately notify the Department in writing and shall include an explanation for the inability to meet the timeframe and a request for approval of an extension of time. The Department may approve, within it sole discretion, any such extension of time upon a showing of good cause by the Contractor. To avoid delayed responses by Contractor caused by a high volume of information or document requests by the Department,

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the Parties shall devise and agree upon a functional method of prioritizing requests so that urgent requests are given appropriate priority.

Contractor shall provide a paid claims listing, in a manner and format as required by the Department, to each of Contractor's Network hospitals as outlined in **Appendix O**. **"Paid Claims Listing Requirements"**. Failure of the Contractor to provide a paid claims listing by the required date in accordance with this Contract shall result in a separate penalty of $50,000 per hospital and a $1,000 per day penalty until provided. An additional penalty of $25,000 will be assessed for any paid claims listing that is not in the required format, or is determined to contain errors or omissions.

38.2 Record System Requirements

The Contractor shall maintain or cause to be maintained detailed records relating to the operation including but not limited to the following:

A. Administrative costs and expenses incurred pursuant to this Contract;
B. Enrollee enrollment status;
C. Provision of Covered Services;
D. All relevant medical information relating to individual Enrollees for the purpose of audit, evaluation or investigation by the Department, the Office of Inspector General, the Attorney General and other authorized federal or state personnel;
E. Quality Improvement and utilization;
F. All financial records, including all financial reports required under Section 38.14 "Financial Reports" of this Contract and A/R activity, rebate data, DSH requests and etc.;
G. Performance reports to indicate Contractor's compliance with Contract requirements;
H. Fraud and abuse;
I. Enrollee/Provider satisfaction and
J. Managerial reports.

All records shall be maintained and available for review by authorized federal and state personnel during the entire term of this Contract and for a period of ten (10) years after termination of this Contract, except that when an audit has been conducted, or audit findings are unresolved. In such case records shall be kept for a period of ten (10) years in accordance with 42 C.F.R. 438.2 and 907 KAR 1:672, or as amended or until all issues are finally resolved, whichever is later.

38.3 Reporting Requirements and Standards

The Contractor shall verify the accuracy for data and other information on reports submitted. Reports or other required data shall be received on or before scheduled due dates. Reports or other required data shall conform to the Department's defined standards. All required information shall be fully disclosed in a manner that is responsive and without material omission.

The Contractor shall analyze all required reports internally before submitting to the Department. The Contractor shall analyze the reports for any early patterns of change, identified trends, or outliers and shall submit this analysis with the required report. The Contractor shall submit a written narrative with the report documenting the Contractor's interpretation of the early patterns of change, identified trend or outlier.

The Contractor shall be responsible for complying with the reporting requirements set forth in this Contract. The Contractor shall be responsible for assuring the accuracy, completeness and timely submission of each report. Reports shall be submitted in electronic format, paper or disk. The Contractor shall provide such additional data and reports as may be reasonably requested by the Department. The Department shall furnish the Contractor with the appropriate reporting formats,

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instructions, timetables for submission and such technical assistance in filing reports and data as may be permitted by the Department's available resources. The Department reserves the right to modify from time to time the form, nature, content, instructions and timetables for the collection and reporting of data. Any requested modification will take cost into consideration.

38.4 COB Reporting Requirements

In order to comply with CMS reporting requirements, the Contractor shall submit a monthly Coordination of Benefits Report for all Enrollee activity. Additionally, Contractor shall submit a report that includes subrogation collections from auto, homeowners, or malpractice insurance, etc.

38.5 QAPI Reporting Requirements

The Contractor shall provide status reports of the QAPI program and work plan to the Department on a quarterly basis thirty (30) working days after the end of the quarter and as required under this section and upon request. All reports shall be submitted in electronic and paper format.

38.6 Enrollment Reconciliation

The Contractor shall reconcile each Enrollee payment identified in a HIPAA 820 transaction with information contained in the HIPAA 834 transaction. The Contractor shall submit all requested corrections to the Department within forty-five (45) days of receipt of HIPAA 820 transaction. Adjustments shall be made to the next HIPAA 820 transaction and/or next available HIPAA 834 transactions to reflect corrections.

38.7 Enrollee Services Report

By the fifteenth (15th) of each month, Contractor shall self-report their prior month performance in call center abandonment rate, blockage rate and average speed of answer, for their Enrollee services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.

38.8 Grievance and Appeal Reporting Requirements

The Contractor shall submit to the Department on a quarterly basis the total number of Enrollee Grievances and Appeals and their disposition. The report shall be in a format approved by the Department and shall include at least the following information:

A. Number of Grievances and Appeals, including expedited appeal requests;
B. Nature of Grievances and Appeals;
C. Resolution;
D. Timeframe for resolution; and
E. QAPI initiatives or administrative changes as a result of analysis of Grievances and Appeals.

The Department or its contracted agent may conduct reviews or onsite visits to follow up on patterns of repeated Grievances or Appeals. Any patterns of suspected Fraud or Abuse identified through the data shall be immediately referred to the Contractor's Program Integrity Unit.

38.9 EPSDT Reports

The Contractor shall submit Encounter Files to the Department's Fiscal Agent for each Enrollee who receives EPSDT Services. This Encounter File shall be completed according to the requirements provided by the Department, including use of specified EPSDT procedure codes

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and referral codes. Annually the Contractor shall submit a report on EPSDT activities, utilization and services and the current Form CMS-416 to the Department.

38.10 Contractor's Provider Network Reporting

The Contractor shall submit to the Department on a quarterly basis, in a format specified by the Department, a report summarizing changes in the Contractor's Network. The Contractor shall report to the Department all provider groups, clinics, facilities and individual physician practices and sites in its network that are not accepting new Medicaid Enrollees. The Contractor shall have procedures to address changes in its network that reduce Enrollee access to services. Significant changes in Contractor's network composition that reduce Enrollee access to services may be grounds for Contract termination.

38.11 DCBS and DAIL Service Plans Reporting

Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for Guardianship, Foster and Adoption Assistance, including Enrollee outcome decisions, such as referral to case management, and rationale for decisions.

38.12 Management Reports

Managerial reports demonstrate compliance with operational requirements of the Contract. These reports shall include, but not be limited to, information on such topics as:

A. Composition of current provider networks and capacity to take on new Medicaid Enrollees;
B. Changes in the composition and capacity of the provider network;
C. PCP to Enrollee ratio;
D. Identification of TPL;
E. Grievance and appeals resolution activities;
F. Fraud and abuse activities;
G. Delegation oversight activities;
H. Enrollee satisfaction; and
I. Out-of-Network utilization by Enrollees.

38.13 Financial Reports

Financial reports demonstrate the Contractor's ability to meet its commitments under the terms of this Contract. The Contractor and its subcontractors shall maintain their accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted system of accounting. The accounting system shall clearly document all financial transactions between the Contractor and its subcontractors and the Contractor and the Department. These transactions shall include, but not be limited to, Claims payment, refunds and adjustment of payments.

The Contractor shall file, in the form and content prescribed by the National Association of Insurance Commissioners (NAIC), within one hundred and twenty days (120) days following the end of each fiscal year an annual audited financial statement that has been prepared by an independent Certified Public Accountant on an accrual basis, in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted system of accounting.

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The Contractor shall also file, within seventy-five (75) days following the end of each fiscal year, certified copies of the annual statement and reports as prescribed and adopted by the DOI. The Department may request information in the form of a consolidated financial statement.

The Contractor shall file within sixty (60) days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

The Contractor shall file with FAC and the Department, within seven (7) days after issuance, a true, correct and complete copy of any report or notice issued in connection with a financial examination conducted by or on behalf of the DOI.

38.14 Ownership and Financial Disclosure

The Contractor agrees to comply with the provisions of 42 C.F.R. 455.104. The Contractor shall provide true and complete disclosures of the following information to FAC, the Department, CMS, and/or their agents or designees, in a form designated by the Department (1) at the time of each annual audit, (2) at the time of each Medicaid survey, (3) prior to entry into a new contract with the Department, (4) upon any change in operations which affects the most recent disclosure report, or (5) within thirty-five (35) days following the date of each written request for such information:

A. The name and address of each person with an ownership or control interest in (i) the Contractor or (ii) any Subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons who are related as spouse, parent, child, or sibling;
B. The name of any other entity receiving reimbursement through the Medicare or Medicaid programs in which a person listed in response to subsection (a) has an ownership or control interest;
C. The same information requested in subsections (A) and (B) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than $25,000 during the immediately preceding twelve-month period;
D. A description of any significant business transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five-year period;
E. The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs;
F. The name of any officer, director, employee or agent of, or any person with an ownership or controlling interest in, the Contractor, any Subcontractor or supplier, who is also employed by the Commonwealth or any of its agencies and
G. The Contractor shall be required to notify the Department immediately when any change in ownership is anticipated. The Contractor shall submit a detailed work plan to the Department and to the DOI during the transition period no later than the date of the sale that identifies areas of the Contract that may be impacted by the change in ownership including management and staff.

The Department shall review the ownership and financial disclosures submitted by the Contractor and any Subcontractor.

38.15 Utilization and Quality Improvement Reporting

Utilization and Quality Improvement reports demonstrate compliance with the Departments

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service delivery and quality standards. These reports shall include, but not be limited to:

A. Trending and analysis reports on areas such as quality of care, access to care, or service delivery access;
B. Encounter data as specified by the Department;
C. Utilization review and management activities data; and
D. Other required reports as determined by the Department, including, but not limited to, performance and tracking measures.

39.0 Records Maintenance and Audit Rights

39.1 Medical Records

Enrollee medical records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.

The Contractor shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA. The Contractor shall protect Enrollee information from unauthorized disclosure as set forth in Section 39.2 "**Confidentiality of Records"**.

The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.

The Contractor shall include provisions in its Subcontracts for access to the medical records of its Enrollees by the Contractor, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, Provider contracts shall provide that when an Enrollee changes PCP, the medical records or copies of medical records shall be forwarded to the new PCP or Partnership within ten (10) Days from receipt of request. The Contractor's PCPs shall have Enrollees sign a release of Medical Records before a Medical Record transfer occurs.

The Contractor shall have a process to systematically review provider medical records to ensure compliance with the medical records standards. The Contractor shall institute improvement and actions when standards are not met. The Contractor shall have a mechanism to assess the effectiveness of practice-site follow-up plans to increase compliance with the Contractor's established medical records standards and goals.

The Contractor shall develop methodologies for assessing performance/compliance to medical record standards of PCP's/PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries services not less than every three (3) years. Audit activity shall, at a minimum:

A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;
B. Allow for the tracking and trending of individual and plan wide provider performance over time;
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and
D. Include mechanism for detecting instances of over-utilization, under-utilization, and misutilization.

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39.2 Confidentiality of Records

The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 C.F.R. Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 41.15 "**Health Insurance Portability and Accountability Act**."

The Contractor shall have written policies and procedures for maintaining the confidentiality of Enrollee information consistent with applicable laws. Policies and procedures shall include but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Enrollee for any needed follow-up and limitations on telephone or mail contact to the home.

The Contractor on behalf of its employees, agents and assignees, shall sign a confidentiality agreement.

Except as otherwise required by law, regulations, or this Contract, access to such information shall be limited by the Contractor and the Department, to persons who or agencies which require the information in order to perform their duties related to the administration of the Department, including but not limited to the U.S. Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of Attorney General, and such others as may be required by the Department.

Any data, information, records or reports which may be disclosed to the Department by the Contractor pursuant to the express terms of this Contract shall not be disclosed or divulged by the Department in whole or in part to any other third person, other than expressly provided for in this Contract, or the Kentucky Open Records Act, KRS 61.870-61.882. The Department and the Contractor agree that this confidentiality provision will survive the termination of this Contract.

Proprietary information, which consists of data, information or records relating to the Contractor, its affiliates' or subsidiaries' business operations and structure, sales methods, practices and techniques, advertising, methods and practices, provider relationships unless otherwise expressly provided for in this Contract, non-Medicaid Enrollee or Enrollee lists, trade secrets, and the Contractor's, its affiliates' or subsidiaries' relationships with its suppliers, providers, potential Enrollees or Enrollees and potential providers, is supplied under the terms of this Contract based on the Department's representation that the information is not subject to disclosure, except as otherwise provided by the Kentucky Open Records Act, KRS 61.870-61.882 or 200 KAR 5:314. The Contractor understands that it must designate information it has which it considers proprietary so that the Department or FAC may claim the proprietary information exemption to KRS 61.878(1)(c) if a request for such information is made. The Contractor also understands that it shall be responsible for defending its Claim that such designated information is proprietary before any applicable adjudicator.

Any requests for disclosure of information received by the Contractor pursuant to this section of the Contract shall be submitted to and received by the Department's Contract Compliance Officer within twenty-four (24) hours as specified in Section 41.16 "**Notices**" of this Contract, and no information for which an exemption from disclosure exists shall be disclosed pursuant to such a request without prior written authorization from the Department. The Department shall notify Contractor if its records are being requested under the Open Records Law.

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However, non-individual identified data and information required to be reported to the Department either by this Contract or by CMS or by applicable laws or regulations, shall not be considered confidential.

39.3 Privacy, Confidentiality, and Ownership of Information

The CHFS is the designated owner of all data and shall approve all access to that data. The Contractor shall not have ownership of Commonwealth data at any time. The Contractor shall be in compliance with privacy policies established by governmental agencies or by state or federal law. Privacy policy statements may be developed and amended from time to time by the Commonwealth and will be appropriately displayed on the Commonwealth portal (Ky.gov). The Contractor shall provide sufficient security to protect the Commonwealth and CHFS data in network transit, storage, and cache.

39.4 Identity Theft Prevention and Reporting Requirements

In the delivery and/or provision of Information Technology hardware, software, systems, and/or services through a contract/s established as a result of this solicitation, the Contractor shall prevent unauthorized access to "Identity Information" of Commonwealth citizens, clients, constituents and employees. "Identity Information" includes, but is not limited to, an individual's first name or initial and last name in combination with any of the following information:

A. Social Security Number;
B. Driver's License Number;
C. System Access ID's and associated passwords; and
D. Account Information –such account number(s), credit/debit/ProCard number(s), and/or passwords and/or security codes.

The Contractor shall also immediately notify the contracting agency, the Office of Procurement Services, and the Commonwealth Office of Technology upon learning of any unauthorized breach/access, theft, or release of Commonwealth data containing "Identity Information."

For even a single knowing violation of these Identity Theft Prevention and Reporting Requirements, the Contractor agrees that the Commonwealth may terminate for default the Contract(s) and may withhold payment(s) owed to the Contractor in an amount sufficient to pay the cost of notifying Commonwealth customers of unauthorized access or security breaches.

39.5 Compliance

The Contractor shall agree to use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") (45 C.F.R. Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996. The Contractor shall ensure that all Contractor actions are compliant with HIPAA rules for access, authentications, storage and auditing, and transmittal of electronic personal health information (e-PHI). Where applicable, The Contractor shall establish and maintain HIPAA compliant controls and procedures that protect, define, and limit circumstances for access, use, and disclosure of personal health information (PHI). An analysis shall be performed by the Contractor during the System Design phase to ensure implementation of appropriate controls for the relevant HIPAA requirements. The Contractor shall not be permitted to use or disclose health information for any reason other than what is mandated within this Contract. All CHFS Projects must adhere to the Commonwealth Office of Technology (COT) security and enterprise policies and procedures and the Cabinet for Health and Family Services (CHFS) security policies and procedures. Below is a listing of additional applicable policies, procedures, and laws for which the proposing Contractors must be prepared to comply:

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A. Computer Fraud and Abuse Act [PL 99-474, 18 USC 1030]
B. Privacy Act of 1974 as amended [5 USC 552a]
C. Protection of Sensitive Agency Information [OMB M-06-16]
D. NIST 800-53 [Moderate]
E. IRS Publication 1075
F. Center for Medicare and Medicaid Services requirements
G. Health Insurance Portability and Accountability (HIPAA)
H. Federal Information Processing Standards (FIPS) Publications

39.6 Application Vulnerability Assessment

Contractor shall perform a non-intrusive vulnerability assessment on web applications and web services; scan the web applications and web services without credentials to identify vulnerabilities related to the OWASP top 10 vulnerabilities and SANS top 25 programming errors; scan the web applications and web services with credentials to identify vulnerabilities related to the OWASP top 10 vulnerabilities and SANS top 25 programming errors.

The initial web applications and web services assessment should be a gray box approach with the chosen Contractor only having knowledge of the IP information, but having no other knowledge with the web application. The chosen Contractor should perform a non-intrusive vulnerability assessment to discover if access can be discovered, programming flaws, data leakage, and information that could allow an intruder to attack the web applications.

The second part of the web applications and web services assessment included a provide role(s) with access to the application(s). The vulnerability assessment of the chosen Contractor will be a non-intrusive security test. A walk through of the application will be very limited and will be at a high level to allow the chosen Contractor to review the application at first glance as a discovery. The high level walk through will include all IPs and URLs only. The application(s) vulnerability assessment should address at the very minimum:

A. Injection
B. Broken Authentication and Session Management
C. Cross-Site Scripting (XSS)
D. Insecure Direct Object References
E. Security Misconfiguration
F. Sensitive Data Exposure
G. Missing Function Level Access
H. Cross-Site Request Forgery (CSRF)
I. Using Known Vulnerable Components
J. Invalidated Redirects and Forwards

The cabinet shall have a copy of the application vulnerability assessment within 14 working days of its execution. The Contractor will provide a mediation plan which meets risk assignment and in agreement with the Commonwealth.

40.0 Remedies for Violation, Breach, or Non-Performance of Contract

40.1 Performance Bond

FAC or the Department shall have the right to enforce the Contractor's Performance Bond pursuant to the terms thereof for any material breach of this Contract after prior written notice to Contractor and an opportunity to cure such material breach within thirty (30) days of the date of the notice, and subject to Contractor's appeal rights pursuant to Section 41.12 "**Disputes**."

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40.2 Violation of State or Federal Law

A finding by any authorized agency that the Contractor has violated any State or Federal Law as it relates to any obligations or requirements under this Contract shall subject the Contractor to immediate withholding, penalty and forfeiture as a Type A violation without the necessity for a Letter of Concern or a Corrective Action Plan.

40.3 Penalties for Failure to Submit Reports and Encounters

A. Appendix K. Reporting Requirements and Reporting Deliverables.

The following regarding reporting requirements and deliverables as found in Appendix K. "Reporting Requirements and Reporting Deliverables" shall be considered Contract violations for which fines shall be imposed:

1. Failure to provide a required report in the allotted timeframe;
2. Submission of incomplete or incorrect reports; or
3. Failure to resolve identified reporting errors within required timelines.

The Department shall notify Contractor of a violation and if the violation is not remedied within five (5) business days, shall fine the Contractor one hundred ($100) dollars per day until the violation is remedied. The fines shall be deducted from the next month's Capitation Payment. This violation shall not require a Letter of Concern or a Corrective Action Plan before fines are imposed.

B. Encounter and Encounter File Submission Deadlines, Errors, and Penalties
   1. Timeliness
      a. Timely Submission of Encounter File. An Encounter File is due on a weekly basis and shall be considered late if not received after five (5) business days from the weekly submission due date. Failure of the Contractor to submit the Encounter File within five (5) business days from the scheduled submission due date shall result in an assessment of $500.00 per day late fee.
      b. Timely Submission of Encounters from Adjudication Date. Encounters shall be submitted within thirty (30) days of the adjudication date. Failure of the Contractor to submit an Encounter File with all of the Encounters within thirty (30) days from the adjudication date is subject to a one dollar $1.00 per day per encounter late fee calculated as follows: the total number of days between adjudication and submission for the Encounter submitted in the Encounter File; 30 days are then subtracted from the days submitted for that Encounter. The late fee of $1.00 per encounter is then assessed for each day over the 30 days.

         An additional penalty for Federally Qualified Health Centers and Rural Health Centers encounters of eleven dollars ($11.00) per day shall be assessed for each day greater than thirty (30) days.

      c. Timely Resubmission of Erred Encounters. Failure to resubmit erred encounter records within sixty (60) days from receipt of the 277U Erred Record Report is subject to a $1.00 per day late fee per encounter over sixty (60) days.

         An additional penalty for Federally Qualified Health Centers and Rural Health Centers encounters of $11.00 per day shall be assessed for each day greater than sixty (60) days.

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d. Timeliness Penalty Cap. Penalties under this section for timeliness shall be capped at 0.33% of the Contractor's monthly capitation rate.

2. Accuracy
   a. Threshold Error. An Encounter File that exceeds a five (5%) percent threshold error rate shall be assessed a per Encounter File error fee of $500.00.
   b. File Not in Required Format. Failure of the Contractor to submit encounter data in the required form or format (as required by DMS, 837, ASC X12 EDI for Electronic Data Interchange and the KY Companion Guide or current industry standard with appropriate KY Companion Guide) for one calendar month shall result in an assessment of $50,000 per file.
   c. Duplicates. Duplicate encounter submissions are subject to a monthly $5.00 per duplicate encounter fee.
   d. Accuracy Penalty Cap. Penalties under this section for accuracy shall be capped at 0.33% of the Contractor's monthly capitation rate.
3. Completeness
   a. Failure to Submit Required Attestation. Failure of the Contractor to submit the required attestation showing all failed files were successfully resubmitted and accepted within sixty (60) days of notification, shall result in an assessment of $10,000 per file. An additional penalty of $1,000 per each late day beyond the sixty (60) days of notification shall also be assessed.
   b. Completeness Penalty Cap. Penalties under this section for completeness shall be capped at 0.33% of the Contractor's monthly capitation rate.

If the Department elects not to exercise any of the penalty clauses herein in a particular instance, this decision shall not be construed as a waiver of the Department's right to pursue the future assessment of that performance standard requirement and associated penalties.

The Department will work with the Contractor to resolve problems in obtaining data at all times. The Contractor acknowledges its responsibility to provide data on Enrollees upon request.

40.4 Kentucky HEALTH Performance Penalties

In addition to any other penalties provided for in this Contract, Contractor shall be penalized as follows for failures to perform its obligations under Section 42 of the Contract.

A. Premium Collection Performance Penalties

The State, or its designee, shall have the right to audit the performance of the Contractor in collecting premiums as required by Section 42.18.1 and the payment files sent by the Contractor to IEES for accuracy and completeness on all required data elements, including, but not limited to: (i) coverage month; (ii) payment date; and (iii) payment status.

For each instance that the Contractor fails to meet a requirement set forth in Section 42.18.1A-E, Contractor shall pay a penalty of $1000.00.

If the results of an audit of payment files indicate that payment files are not one hundred percent (100%) accurate and complete, the Contractor shall pay a penalty in an amount that corresponds the percentage of error to the percentage of capitation payment received by the Contractor during the audit period for the Kentucky HEALTH population. For example, If the audit indicates an error rate of 5%, then Contractor shall be penalized 5% of the total capitation payments received by it during the audit period for the Kentucky HEALTH population.

B. Medically Frail Identification Performance Penalties

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The Contractor shall be subject to an audit of Kentucky HEALTH Medically Frail determinations made pursuant to Section 42.12.3. The Department may use a contracted entity to conduct the audit. If the results of the audit indicate that inappropriate determinations have been made in greater than ten percent (10%) of the audited cases, the Contractor shall pay a penalty in an amount that corresponds the percentage of error above 10% to the percentage of capitation payment received by the Contractor during the audit period for the Kentucky HEALTH population:

Prior to imposing sanctions, the Contractor, at its sole expense, shall have the right to dispute the audit findings. The Contractor may present to the Department documentation used to determine whether the Member met the Medically Frail criteria. Sanctions shall not be imposed if the Department determines, based upon this documentation, that a Member met the Medically Frail criteria at the time of the determination.

C. My Rewards Account Performance Penalties

The Contractor shall be responsible for transmitting data for the My Rewards Account in accordance with Kentucky HEALTH Business Requirements and Section 42.15 "My Rewards Account," for activities completed by Kentucky HEALTH Members. For each instance in which the Contractor fails to transmit completion of activities which qualify a Member for My Rewards Account accrual, the Contractor shall pay a penalty in the amount of $1000.00.

40.5 Requirement of Corrective Action

A. Letter of Concern

Should the Department determine that the Contractor or any Subcontractor is in violation of any requirement of this Contract, the Department shall issue a "Letter of Concern." The Contractor shall contact the Department's representative designated by the Department within two (2) business days of receipt of the Letter of Concern and shall indicate how such concern is unfounded or how it will be addressed. If the Contractor fails to timely contact the designated representative regarding a Letter of Concern, the Department shall proceed to the additional enforcement contained in this Contract.

B. Corrective Action Plan

Should FAC or the Department determine that the Contractor or any Subcontractor is not in substantial compliance with any material provision of this Contract, FAC or the Department shall issue a Written Deficiency Notice to the Contractor specifying the deficiency and requesting a corrective action plan be filed by the Contractor within ten (10) business days following the date of the notice.

A corrective action plan shall delineate the time and manner in which each deficiency is to be corrected. The plan shall be subject to approval by FAC or the Department, which may accept the plan as submitted, may accept the plan with specified modifications, or may reject the plan within ten (10) business days of receipt. FAC or the Department may reduce the time allowed for corrective action depending upon the nature of the deficiency.

C. Failure to Respond to Letter of Concern or Corrective Action Plan Notice

Failure of the Contractor to respond to a Letter of Concern within two (2) business days of receipt of the Letter of Concern shall result in a $500.00 per day penalty for each day until

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the response is received. Failure of the Contractor to submit a Corrective Action Plan within ten (10) business days following the date of the Written Deficiency Notice shall result in a $1000.00 per day penalty for each day until the Corrective Action Plan is received.

D. Request for Extension

Upon request, FAC or the Department may extend the time allowed for both a response to the Letter of Concern and a Corrective Action Plan. The Contractor may request an extension of time in writing from the representative designated in the Letter of Concern or the Written Deficiency Notice. An extension shall be requested no later than one (1) business day prior to the date the response is due. The written request shall contain a justification and proposed extension period. If an extension is granted, the penalty per day for both a late Letter of Concern or a late Corrective Action Plan would begin after the expiration of the extension period.

40.6 Penalties for Failure to Correct

A. Civil Money Penalties

Following failure on the part of the Contractor to cure a default in accordance with a plan of correction under Section 40.4 "Requirement of Corrective Action," FAC or the Department may impose civil money penalties in the circumstances and the amounts set forth below if the Contractor does any of the following:

1. Fails substantially to provide Medically Necessary items and services that are required under law and under this Contract ($25,000);
2. Imposes excess premiums and charges; (The maximum amount of the penalty shall be $25,000 or double the excess amount charged, whichever is greater. The Department shall deduct the amount of the overcharge from the penalty and return it to the affected Enrollee);
3. Acts to discriminate among Enrollees; (an amount not to exceed $100,000);
4. Misrepresents or falsifies information; (an amount not to exceed $100,000);
5. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. §§422.208 and 422.210 ($25,000);
6. Violates marketing guidelines ($10,000);
7. Prompt Pay Violations ($1,000 per infraction);
8. Finding of substantial non-compliance that affects Enrollee's access to services ($5,000);
9. Network Program Adequacy/ Capacity ($10,000);
10. Failure to respond sufficiently to an LOC ($1,000);
11. Failure to respond sufficiently to a Corrective Action Plan request ($5000);
12. Failure to timely implement a Corrective Action Plan;
13. Failure to submit correct data ($1,000) except for encounter submission or if otherwise addressed in the Contract; or
14. Repeated contractual violation:
    a. 1st Offense ($5,000);
    b. 2nd Offense ($10,000);
    c. 3rd-6th Offense ($20,000); and
    d. 7th Offense and each subsequent offense ($40,000).

B. Withholding, Penalty and Forfeiture

Upon the issuance of a Written Deficiency Notice requiring a corrective action plan, the Department shall withhold one quarter of one (0.25%) percent of one monthly Capitation Payment for Type B deficiencies until the corrective action has been completed. The

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Department shall impose a nonrefundable penalty of $10,000 for each Type B infraction. The Department shall withhold one-half of one (0.5%) percent of one monthly Capitation Payment for Type A deficiencies until the corrective action has been completed. The Department shall impose a nonrefundable penalty of $50,000 for each Type A infraction.

If the deficiency is not remedied within three (3) months from acceptance of the corrective action plan, one-half of the funds withheld shall be forfeited in addition to the nonrefundable penalty referenced above. If the deficiency is not remedied within six (6) months from acceptance of the corrective action plan, all of the funds withheld shall be forfeited in addition to the nonrefundable penalty referenced above.

Type A deficiencies shall be a written deficiency in the requirements in the following sections: 23 through 37, inclusive.

Type B deficiencies shall be a written deficiency in the requirements in the following sections: 3-15, 17-22, 38 and 41.

40.7 Penalties for Failure to Respond to Requests

For requests not otherwise specifically addressed in this Contract, if the Contractor either fails to respond or fails to submit a complete or accurate written response to a Department's written request within the designated timeframe, the Department may impose a $500.00 per day penalty until the response is received, complete or accurate, whichever is applicable.

40.8 Appeal of Penalties Established in 40.5.A or 40.6

Prior to exercising the dispute provision of Section 41.12, the Contractor may request reconsideration of a penalty imposed in accordance with 40.5.A or 40.6 that equals or exceeds $50,000 by sending a letter to the Commissioner of the Department for Medicaid Services, or his/her designee, within thirty (30) days of receipt of notification of the penalty.

40.9 Notice of Contractor Breach

A Contractor shall be considered in breach if the Contractor is not in substantial compliance with any material provision of this Contract that cannot be cured or if the Contractor fails to cure a default in accordance with a plan of correction under Section 40.4 "**Requirement of Corrective Action**," or comply with Sections 1932, 1903(m), and 1905(t) of the Social Security Act, or 42 C.F.R. 438. FAC shall issue a timely written notice to the Contractor, explaining any appeal rights provided to the Contractor, indicating the nature of the default, and advising the Contractor that failure to cure the default within a defined time period to the satisfaction of the Department, may lead to the imposition of any sanction or combination of sanctions provided by the terms of this Contract, or otherwise provided by law, including but not limited to all of the following:

A. Suspension of further Enrollment for a defined time period;
B. Suspension of Capitation Payments;
C. Suspension or recoupment of the Capitation Rate paid for any month for any Enrollee who was denied the full extent of Covered Services meeting the standards set by this Contract, or who received or is receiving substandard services;
D. A claim against Contractor's Performance Bond;
E. Appoint temporary management;
F. Grant Enrollees the right to disenroll without cause; and
G. Termination of the contract.

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The Department shall impose mandatory temporary management when a Contractor repeatedly fails to meet substantive requirements established in Sections 1903(m) or 1932 of the Social Security Act or 42 C.F.R. 438. The Department shall not delay the imposition of temporary management to provide a hearing and shall not terminate temporary management until it determines that the Contractor can ensure the sanctioned behavior will not reoccur. If the Department imposes temporary management, the Department shall notify affected Enrollees of their right to terminate enrollment without cause, pursuant to 42 C.F.R. 438.706(b).

40.10 Additional Sanctions Required by CMS

Payments provided for under this Contract will be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by CMS under 42 C.F.R. 438.730(e).

40.11 Termination for Default

In addition to nonperformance of the particular terms and conditions of this Contract by the Contractor, each of the following shall constitute breach of the Contract by Contractor for which actual and consequential money damages and any of the other remedies set forth in the Contract are available to FAC, as well as a remedy of immediate termination of this Contract if the problem is not cured in the time frame specified by the Department:

A. The conduct of the Contractor, any Subcontractor or supplier, or the standard of services provided by or on behalf of the Contractor, fails to meet the Department's minimum standards of care or threatens to place the health or safety of any group of Enrollees in jeopardy;
B. The Contractor is either expelled or suspended from the federal health insurance programs under Title XVIII or Title XIX of the Social Security Act;
C. Contractor's license to operate as an HMO is suspended or terminated by the DOI, or any adverse action is taken by the DOI which is deemed by the Department to affect the ability of the Contractor to provide health care services as set forth in this Contract to Enrollees;
D. The Contractor fails to maintain protection against fiscal insolvency as required under state or federal law, or as required by the terms of this Contract, or the Contractor fails to meet its financial obligations as they become due other than with respect to contested or challenged Claims filed by Enrollees or Providers;
E. The Contractor fails to or knowingly permits any Subcontractor, supplier, or any other person or entity who receives compensation pursuant to performance of this Contract, to fail to comply with the nondiscrimination and affirmative action requirements of Section 5.3 "Nondiscrimination and Affirmative Action" of this Contract;
F. The Contractor provides or knowingly permits any Subcontractor to provide fraudulent, or intentionally misleading or misrepresentative information to any Enrollee, or to any agent of the Commonwealth or the United States in connection with; or
G. Gratuities other than de minimus or otherwise legal gratuities are offered to, or received by, any public official, employee or agent of the Commonwealth from the Contractor, its agent's employees, Subcontractors or suppliers, in violation of Offer of Gratuities and Affirmative Action of this Contract;
H. The Contractor violates any of the confidentiality provisions of this Contract; or
I. The Contractor fails to provide covered services to its Enrollees.

As part of FAC's option to terminate, if the Contractor is in uncured material breach of the Contract or is insolvent, the Department has the option to assume the rights and obligations of the Contractor and directly operate the Contractor's network, using the existing Contractor's administrative organization, to ensure delivery of care to Enrollees through the Contractor's Network until cure by the Contractor of the breach or by demonstrated financial solvency, or until the successful transition of those Enrollees to other MCOs at the expense of the Contractor.

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The certification by the Commissioner of the Department of the occurrence of any of the events stated above shall be conclusive. The Contractor, however, shall retain all rights to dispute resolution specified in **Disputes** of this Contract.

Before terminating the Contract under 42 C.F.R. 438.708, FAC must provide the Contractor with a pre-termination hearing. The State shall give the Contractor written notice of its intent to terminate, the reason for termination, and the time and place of hearing. FAC shall give the Contractor, after the hearing, written notice of the decision affirming or reversing the proposed termination of the Contract, and for an affirming decision, the effective date of termination. For an affirming decision, the Department shall give Enrollees notice of the termination and information, consistent with 42 C.F.R. 438.10 on their options for receiving Medicaid services following the effective date of termination

40.12 Obligations upon Termination

Upon termination of this Contract before the end of its term regardless of cause except for the convenience of the Commonwealth, the Contractor shall be solely responsible for the provision and payment for all Covered Services for all Enrollees for the remainder of any month for which the Department has paid the monthly Capitation Rate. Contractor may be requested to continue in place for two additional months. Upon final notice of termination, on the date, and to the extent specified in the notice of termination, the Contractor shall:

A. Provide a written Transition Plan for the Department's approval. In the event of Contract termination, the Transition Plan shall be due within ten (10) calendar days of receiving Notice of Termination from the Commonwealth. The Contractor will revise and resubmit the Transition Plan to the Department on a regular basis, the frequency of which will be determined by the Department;
B. Appoint a liaison for post-transition concerns;
C. Provide for sufficient claims payment staff, Enrollee services staff, and provider services staff to ensure a smooth transition;
D. Continue providing Covered Services to all Enrollees until midnight on the last day of the calendar month for which a Capitation Payment has been made by the Department;
E. Continue providing all Covered Services to all infants of female Enrollees who have not been discharged from the hospital following birth, until each infant is discharged, or for the period specified in (a) above, whichever period is shorter;
F. Continue providing inpatient hospital services to any Enrollees who are hospitalized on the termination date, until each Enrollee is discharged, or for the period specified in (a) above, whichever period is shorter;
G. Arrange for the transfer of Enrollees and medical records to other appropriate Providers;
H. Be responsible for resolving Enrollee grievances and appeals with respect to claims with dates of service prior to the date of contract termination or expiration, including those grievances and appeals filed on or after the day of termination or expiration for those dates of service;
I. Be financially responsible for Enrollee appeals of adverse decisions rendered by the Contractor concerning treatment of services requested prior to termination or expiration of the Contract which are subsequently upheld on behalf of the Enrollee after an appeal proceeding or after a State Fair Hearing.
J. Be responsible for submitting encounter data for all claims incurred for dates of service prior to contract termination.
K. Be responsible for submitting all reports necessary to facilitate the collection of pharmacy rebates and assisting in the resolution of all drug rebate disputes with the manufacturer for all claims incurred prior to the contract termination date;
L. Be responsible for submitting all performance data with a due date following the termination or expiration of the Contract, but covering a reporting period prior to termination or expiration of the Contract;

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M. Promptly supply to the Department such information as it may request respecting any unpaid Claims submitted by Out-of- Network Providers and arrange for the payment of such Claims within the time periods provided herein;
N. Provide the Department will all information requested in the format and within the timeframe set forth by the Department, which shall be no later than thirty (30) calendar days of the request;
O. Take such action as may be necessary, or as the Department may direct, for the protection of property related to this Contract, which is in the possession of the Contractor and in which the Department has or may acquire an interest; and
P. Provide for the maintenance of all records for audit and inspection by the Department, CMS and other authorized government officials, in accordance with terms and conditions specified in this Contract including the transfer of all such data and records, or copies thereof, to the Department or its agents as may be requested by the Department; and the preparation and delivery of any reports, forms or other documents to the Department as may be required pursuant to this Contract or any applicable policies and procedures of the Department.

The covenants set forth in this Section shall survive the termination of this Contract and shall remain fully enforceable by FAC against the Contractor. In the event that the Contractor fails to fulfill each covenant set forth in this Section, the Department shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such covenants, all at the sole cost and expense of the Contractor and the Contractor shall refund to the Department all sums expended by the Department in so doing.

After FAC notifies the Contractor that it intends to terminate the Contract, the Department may provide the Enrollees written notice of FAC's intent to terminate the Contract and allow the Enrollees to disenroll immediately without cause.

40.13 Liquidated Damages

If the Contractor breaches the Contract and the actual and consequential damages caused by that breach cannot be demonstrated, the Contractor shall pay to the Department liquidated damages up to ten percent (10%) of the Contractor's annual Capitation Payment. Such payment is to be made no later than thirty (30) days following the date of termination. FAC and the Contractor agree that the sum set forth herein as liquidated damages is a reasonable pre-estimate of the probable loss which will be incurred by the Department in the event this Contract is terminated prior to the end of the Contract term and actual or consequential money damages cannot be demonstrated.

If this Contract is terminated by FAC for convenience as specified in Section 40.12 "**Termination for Convenience**" of this Contract, the Contractor may seek a remedy pursuant to 200 KAR 5:312.

40.14 Right of Set Off

The Contractor hereby grants to FAC a lien and right of set off for any refund and liquidated damages due the Department pursuant to this Contract, upon and against any deposits, credits, payments due or other property of the Contractor at any time in the possession or control of the Department or in transit to the Department.

40.15 Annual Contract Monitoring

FAC or the Department retains the right to withhold payment if the Contractor does not comply with programmatic and fiscal reporting and monitoring requirements following failure on the part of the Contractor to cure a default in accordance with a plan of correction under Section 40.4

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"**Requirement of Corrective Action**."

40.16 Termination for Convenience

FAC upon thirty (30) days prior written notice to the Contractor may terminate this Contract without cause. Termination shall be effective only at midnight of the last day of a calendar month, except for termination notices received in June, which termination shall be effective on June 30. In the event of such a termination, Contractor shall have a transition period of not less than three (3) nor more than six (6) months to transition services, during which time the terms and conditions of this Contract shall continue to apply, and Contractor shall provide Covered Services to, and shall be paid pursuant to the Capitation Rate set forth herein for, each Enrollee up to and including the date of transition of such Enrollee.

40.17 Funding Out Provision

The Contractor agrees that if funds are not appropriated to the Department or are not otherwise available for the purpose of making payments, the Commonwealth shall be authorized, upon sixty (60) days written notice to the Contractor to terminate this Contract. The termination shall be without any other obligation or liability of any cancellation or termination charges, which may be fixed by this Contract.

41.0 Miscellaneous

41.1 Documents Constituting Contract

This Contract shall include

A. This Medicaid Managed Care Contract;
B. The Appendices to this Contract;
C. The Request for Proposal and all attachments and addendums thereto, including Section 40--Terms and Conditions of a Contract with the Commonwealth of Kentucky, where applicable;
D. General Conditions contained in 200 KAR 5:021 and Office of Procurement Services' FAP110-10-00; and
E. The Contractor's proposal in response to the RFP. Provided however, by submitting materials in response to the RFP, the Contractor has not fulfilled any obligation under this Contract to submit plans, programs, policies, procedures, forms or documents, etc. to the Department for approval as required by this Contract.

In the event of any conflict between or among the provisions contained in the Contract, the order of precedence shall be as enumerated above. The documents listed above constitute the entire agreement between the parties.

41.2 Definitions and Construction

The terms used in this Contract shall have the definitions set forth in Section 1 "**Definitions**," unless this Contract expressly provides otherwise. References to numbered sections refer to the designated sections contained in this Contract. Titles of sections used in this Contract are for reference only and shall not be deemed to be a part of this Contract.

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41.3 Amendments

This Contract may be amended at any time by written mutual consent of the Contractor and FAC and the Department, and upon approval of CMS. In the event that changes in state or federal law require the Department to amend its Contract with the Contractor, notice shall be made to the Contractor in writing and any such amendment shall be subject to the applicable payment rate revision provisions as described in Section 11.2 "**Rate Adjustments**." The Department may, from time to time provide clarification of the Providers' and the Contractor's responsibilities, provided, however, such clarification shall not expand or amend the duties and obligations under this Contract without an amendment.

41.4 Notice of Legal Action

The Contractor shall provide written notice to FAC of any legal action or notice listed below, within ten (10) days following the date the Contractor receives written notice of:

A. Any action, proposed action, lawsuit or counterclaim filed against the Contractor, or against any Subcontractor or supplier, related in any way to this Contract;
B. Any administrative or regulatory action, or proposed action, respecting the business or operations of the Contractor, any Subcontractor or supplier, related in any way to this Contract;
C. Any notice received from the DOI or the Cabinet for Health and Family Services;
D. Any claim made against the Contractor by an Enrollee, Subcontractor or supplier having the potential to result in litigation related in any way to this Contract;
E. The filing of a petition in bankruptcy by or against a Subcontractor or supplier, or the insolvency of a Subcontractor or supplier; and
F. The payment of a civil fine or conviction of any person who has an ownership or controlling interest in the Contractor, any Subcontractor or supplier, or who is an agent or managing employee of the Contractor, any Subcontractor or supplier, of a criminal offense related to that person's involvement in an program under Medicare, Medicaid, or Title XX of the Act, or of Fraud, or unlawful manufacture, distribution, prescription or dispensing of a controlled substance, as specified in 42 USC 1320a-7.

A complete copy of all documents, filings or notices received by the Contractor shall accompany the notice to FAC. A complete copy of all further filings and other documents generated in connection with any such legal action shall be provided to FAC within ten (10) days following the date the Contractor receives such documents.

41.5 Conflict of Interest

By the signature of its authorized representative, the Contractor certifies that it is legally entitled to enter into this Contract with the Commonwealth, and in holding and performing this Contract, the Contractor does not and will not violate either applicable conflict of interest statutes (KRS 45A.330-45A.340, 45A.990, 164.390), or KRS 11A.040 of the Executive Branch Code of Ethics, relating to the employment of former public servants.

41.6 Offer of Gratuities/Purchasing and Specifications

The Contractor certifies that no Enrollee or delegate of Congress, nor any elected or appointed official, employee or agent of the Commonwealth, the Kentucky Cabinet for Health and Family Services, CMS, or any other federal agency, has or will benefit financially or materially from this procurement. This Contract may be terminated by FAC pursuant to Section 40.7 "**Termination for Default**," herein if it is determined that gratuities were offered to or received by any of the

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aforementioned officials or employees from the Contractor, its agents, employees, Subcontractors or suppliers.

The Contractor certifies by its signatories hereinafter that it will not attempt in any manner to influence any specifications to be restrictive in any way or respect nor will it attempt in any way to influence any purchasing of services, commodities or equipment by the Commonwealth. For the purpose of this paragraph, "it" is construed to mean any person with an interest therein, as required by applicable law.

41.7 Independent Capacity of the Contractor and Subcontractors

It is expressly agreed that the Contractor and any Subcontractors and agents, officers, and employees of the Contractor or any Subcontractors shall act in an independent capacity in the performance of this Contract and not as officers or employees of the Department or the Commonwealth. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the Contractor or any Subcontractor and the Department or the Commonwealth.

41.8 Assignment

Except as allowed through subcontracting, this Contract and any payments that may become due hereunder shall not be assignable by the Contractor, either in whole or in part, without prior written approval of FAC. The transfer of five percent (5%) or more of the direct ownership in the Contractor at any time during the term of this Contract shall be deemed an assignment of this Contract. FAC shall be entitled to assign this Contract to any other agency of the Commonwealth which may assume the duties or responsibilities of the Department relating to this Contract. FAC shall provide written notice of any such assignment to the Contractor, whereupon the Department shall be discharged from any further obligation or liability under this Contract arising on or after the date of such assignment.

41.9 No Waiver

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract may be waived except by written agreement of the parties. The forbearance or indulgence in any form or manner by either party shall not constitute a waiver of any covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Until complete performance or satisfaction of all such covenants, conditions, duties, obligations, or undertakings, the other party shall have the right to invoke any remedy available under law or equity, notwithstanding any such forbearance or indulgence.

41.10 Severability

In the event that any provision of this Contract (including items incorporated by reference) is found to be unlawful, invalid or unenforceable, such provision shall be deemed severed from this Contract and FAC the Department and the Contractor shall be relieved of all obligations arising under such provision. If the remaining parts of this Contract are capable of performance, this Contract shall continue in full force and effect, and all remaining provisions shall be binding upon each party to this Contract as if no such unlawful, invalid or unenforceable provision had been part of this Contract. If the laws or regulations governing this Contract should be amended or judicially interpreted so as to render the fulfillment of this Contract impossible or economically not feasible, as determined jointly by FAC, the Department and the Contractor, FAC, the Department and the Contractor shall be discharged from any further obligations created under the terms of this Contract.

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41.11 Force Majeure

The parties shall be excused from performance thereunder for any period that it is prevented from providing, arranging for, or paying for services as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

41.12 Disputes

Any disputes arising under this Contract which cannot be disposed of by agreement between the parties, shall be decided by the Secretary of the Cabinet for Health and Family Services or his/her duly authorized representative. Such decision shall be produced in writing and sent via first-class mail to the Contract Compliance Officer for the Contractor at the address specified in Section 41.16 "**Notices"** of this Contract. The decision of the Secretary or his representative shall be final and conclusive unless, within ten (10) working days following the date of notice to the Contractor of such decision, the Contractor mails or otherwise furnishes a written appeal to the Secretary of FAC.

Any appeal to the Secretary of FAC shall be in accordance with KRS Chapter 45A.225 et seq. and regulations promulgated thereunder. The Contractor shall proceed diligently with the performance of this Contract in accordance with the decision rendered by the Secretary of the Cabinet for Health and Family Services until the Secretary of the Finance and Administration Cabinet renders a final decision.

The Contractor acknowledges that, pursuant to KRS Chapter 45A.225 et seq., the Secretary of the Finance and Administration Cabinet is the final arbiter of any and all disputes concerning the Contract or the Department, subject to the right of the Contractor to appeal any such determination to the Circuit Court of Franklin County, Kentucky.

41.13 Modifications or Rescission of Section 1915 Waiver / State Plan Amendment

It is understood Contractor operates either pursuant to authority granted to the Department under a waiver granted by CMS. Notwithstanding any other provision contained herein, if at any time the waiver is rescinded or materially changed in scope, format, funding or is withdrawn or modified the Department reserves the right to immediately and without notice suspend or terminate this Contract pursuant to Sections 40.1 through 40.13 "**Remedies for Violation, Breach or Non-Performance of Contract"** herein.

41.14 Choice of Law

The Contract shall be governed by and construed in accordance with the laws of the Commonwealth and applicable federal law and regulations. The Contractor shall be required to bring all legal proceedings against the Commonwealth in the Franklin County Circuit Court of the Commonwealth and the Contractor shall accept jurisdiction of the Kentucky courts over all matters arising out of this Contract.

41.15 Health Insurance Portability and Accountability Act

The Contractor agrees to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 C.F.R. Parts 160 and 164. Any Subcontract entered by the Contractor as a result of this Contract shall mandate that the Subcontractor be required to abide by the same statutes and regulations regarding confidentiality of protected health information as are the Contractor.

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41.16 Notices

All notices required by, or pursuant to, this Contract shall be deemed duly given upon delivery, if delivered by hand (against receipt), or three (3) business days after posting, if sent by registered or certified mail, return receipt requested, to a party's representative or representatives, as designated in this Contract at the address or addresses designated in this Contract. Notices to FAC and the Department, except those specified to be given to the Department's Fiscal Agent, shall be given to both of the following:

Finance and Administration Cabinet
Office of Procurement Services
Attn: Executive Director
Room 96 Capitol Annex

Frankfort, Kentucky 40601

Department for Medicaid Services
Commissioner
275 East Main Street, 6W-A
Frankfort, Kentucky 40621

Notices to the Contractor shall be given to the designated point of contact.

41.17 Survival

The provisions of this Contract which relate to the obligations of the Contractor to maintain records and reports shall survive the expiration of earlier termination of this Contract for a period of five (5) years or such other period as may be required by record retention policies of the Commonwealth or CMS, or otherwise required by law. Each party's right to recoupment pursuant to Section 10.4 "**Contractor Recoupment from Enrollee for Fraud, Waste and Abuse**" of this Contract shall survive the expiration or earlier termination of this Contract until such time as all payments and/or recoupment have been finally settled.

FAC's, the Department's and the Contractor's rights pursuant to Sections 13.1through 13.5 "**Contractor's Financial Security Obligations**" of this Contract shall survive expiration, or earlier termination of this Contract, until such time as the Contractor has satisfactorily complied with the terms thereof.

41.18 Prohibition on Use of Funds for Lobbying Activities

The contractor agrees that no funding derived directly or indirectly from funds pursuant to this Contract shall be used to support lobbying activities or expenses of state or federal government agencies or state or federal lawmakers.

41.19 Adoption of Auditor of Public Account (APA) Standards for Public and Nonprofit Boards

The contractor agrees to adopt the APA Standards for Public and Nonprofit Boards, if applicable. The contractor agrees to provide documentation of this adoption within thirty (30) days of execution of the Contract.

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41.20 Review of Distributions

The Contractor agrees to seek approval from the Department prior to submitting a request for approval of the Kentucky Department of Insurance of any distributions of capital and surplus that are subject to the provisions of KRS Chapter 304. The parties agree that capital and surplus amounts in excess of the required minimum amount required to be maintained under the Kentucky Insurance Code or as may be determined by the Kentucky Insurance Commissioner at any time represents net worth assets for the purposes of benefitting the Commonwealth of Kentucky's Medicaid Program and its beneficiaries. The parties agree to make a good faith effort to cooperatively decide how much excess capital and surplus is needed by the contractor and possible uses of excess capital and surplus that should not be retained by the contractor. This Section shall not apply in the event the Contractor is not domiciled in the Commonwealth of Kentucky, provided, however that on a semi-annual basis Contractor shall provide the Department with medical loss ratio calculations relating specifically to this Contract and risk-based capital calculations, and on a quarterly basis Contractor shall provide to the Department the most recent quarterly financial filing that the Contractor submitted to the Department of Insurance in its state of domicile.

41.21 Audits

The Contractor agrees that the Department, FAC, the Auditor of Public Accounts, and the Legislative Research Commission, or their duly authorized representatives, shall have access to any books, documents, papers, records, or other evidence, which are directly pertinent to this contract for the purpose of financial audit or program review. Records and other prequalification information confidentially disclosed as part of the bid process shall not be deemed as directly pertinent to the contract and shall be exempt from disclosure as provided in KRS 61.878(1)(c). The contractor also recognizes that any books, documents, papers, records, or other evidence, received during a financial audit or program review shall be subject to the Kentucky Open Records Act, KRS 61.870 to 61.884 subject to applicable exceptions

41.22 Cost Effective Analyses

The Contractor will cooperate with any analyses conducted by the Department or its agent(s) of the cost effectiveness of the Contract for any period. Such analyses may review cost effectiveness from any number of comparisons. Such analyses will be used to assist the Department to meet federal requirements, program management and provide accountability and transparency to the public.

41.23 Open Meetings and Open Records

The Contractor agrees that only those portions of its Board of Directors meetings or parts of its meetings that are with the Department shall be open to the public.

The Contractor for the purpose of this Contract and any documents or records pertaining to this Contract provided to the Department or FAC shall be considered a "public record" under the Open Records Act, KRS 61.870 through KRS 61.884. If the Contractor wishes to claim any documents or records provided to the Department or FAC exempt from release under the Open Records Act, the Contractor shall be required to note the appropriate exemption when providing the documents or records and, if necessary, to take the appropriate legal actions to defend such exemption.

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41.24 Disclosure of Certain Financial Information

The Contractor agrees to provide the Department upon request information regarding salaries, travel, other compensation, and other expenses listed in **Appendix K. "Reporting Requirements and Reporting Deliverables."** The contractor agrees to provide any information requested by the Department regarding expenditures related to this Contract. Including but not limited to any findings of the Medicaid Managed Care Operations Examination.

41.25 Disclosure of Certain Financial Information

The Contractor agrees to provide the Department, upon request, information regarding salaries, travel, other compensation, and other expenses listed in **Appendix K. "Reporting Requirements and Reporting Deliverables."** The contractor agrees to provide any information requested by the Department regarding expenditures related to this Contract. Including but not limited to any findings of the Medicaid Managed Care Operations Examination.

42.0 Kentucky HEALTH Policies and Performance Requirements

The provisions of this section are intended to implement and support the Kentucky Health Waiver project. To the extent that any provisions in this section conflict with the preceding provisions of the Contract for the populations known as Kentucky HEALTH Enrollees, set forth in Section 42.1, the provisions of Section 42 shall control.

The Contractor shall apply Kentucky HEALTH policies as outlined in this Section to all Kentucky HEALTH Enrollees. The requirements of this Section shall not apply to Enrollees assigned to the Kentucky HEALTH Random Control Trial (RCT). The Contractor shall comply with all requirements of the Kentucky HEALTH Special Terms and Conditions (STCs).

42.1 Kentucky HEALTH Enrolled Populations

The following eligibility groups shall be enrolled in Kentucky HEALTH:

A. ACA Expansion Enrollees;
B. Parents and Caretaker Relatives;
C. Transitional Medical Assistance (TMA);
D. Pregnant Women;
E. Former Foster Youth;
F. Kentucky HEALTH Children; and
G. KCHIP Enrollees.

42.2 Enrollment Effective Date

The Contractor shall provide coverage to Kentucky HEALTH Enrollees in accordance with the HIPAA 834 effective date information. Pregnant Women, Former Foster Youth and Kentucky HEALTH Children, with the exception of Deemed Newborns as described in 42 CFR §435.117, shall have retroactive eligibility effective up to three (3) months prior to Medicaid application, to the extent that the conditions of 42 CFR §435.915 are met. Deemed Newborns shall have eligibility from the date of birth if the conditions of 42 CFR §435.117 are met. The Contractor shall be responsible for coverage of benefits during periods of retroactivity as described in Section 27.8 "Persons Eligible for Enrollment and Retroactivity."

ACA Expansion Enrollees, Parents and Caretaker Relatives, and TMA Enrollees shall not receive retroactive eligibility. Their eligibility effective date is contingent upon the date of initial premium

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payment; they shall be deemed Conditionally Eligible Enrollees prior to initial premium payment. Upon such payment, Conditionally Eligible Enrollees shall become eligible for Kentucky HEALTH, effective the first day of the month of initial premium payment. Conditionally Eligible Enrollees whose household income is at or below one hundred percent (100%) FPL who do not make an initial premium payment within sixty (60) days of the Contractor's invoice date shall become eligible for Kentucky HEALTH under the Copayment Plan effective the first day of the month in which the sixty (60) day premium payment period expired.

Kentucky HEALTH Enrollees who make a Fast Track Payment, as further described in Section 42.3 "Fast Track Enrollment," shall be enrolled in Kentucky HEALTH effective the first day of the month in which the Fast Track Payment was made.

Kentucky HEALTH Enrollees who are determined Medically Frail at the time of application, as described in Section 42.12.1 "State Identification of Medically Frail," shall be eligible for enrollment on the first day of the month of application.

42.3 Fast Track Enrollment

Applicants shall be given the opportunity to expedite enrollment into the Premium Plan by making a Fast Track Payment, in accordance with the Kentucky HEALTH Business Requirements. If determined eligible for coverage, submission of a Fast Track Payment shall render a Kentucky HEALTH Enrollee eligible for Kentucky HEALTH coverage effective the first day of the month that the payment is made, which may be as early as the first day of the month of application. If the applicant's eligibility is pending upon electronic application for a reason other than income verification, the amount of the Fast Track Payment shall be a premium dollar amount defined by the Department. If eligibility is determined in real time and the individual is a Conditionally Eligible Enrollee, or has submitted an application which is pending but whose income has been verified, the Fast Track Payment shall be the calculated premium amount determined in accordance with Section 42.5.2 "Premiums." The Department shall establish the dollar amount of the Fast Track Payment and may adjust the amount at any time. The Department shall provide the Contractor at least sixty (60) days advance written notice of any change in the dollar amount of the Fast Track Payment.

The opportunity to make a Fast Track Payment shall not be available to applicants who are in a Presumptive Eligibility period. Notwithstanding the foregoing, if an Enrollee in a Presumptive Eligibility period submits a Medicaid application with other household Enrollees who are not in a Presumptive Eligibility period, the case will have a Fast Track option; however, the Enrollee in a Presumptive Eligibility period shall not be eligible to transfer to the Premium Plan until the next administratively feasible month, in order to avoid an overlap in coverage in the Copayment Plan.

Applicants who select the option to make a Fast Track Payment on the application shall also select whether to join the Contractor's network. Once both selections are made, the Cabinet shall direct the applicant to the Contractor's electronic payment portal.

The Contractor shall establish and maintain an electronic portal for Fast Track Payments which integrates with the IEES electronic application portal, and by which Fast Track Payments may be accepted. The Contractor's electronic portal shall display language, which meets the readability requirements of Section 23.5 "Enrollee Information Materials," indicating the implications for an applicant's enrollment effective date in the event that a Fast Track Payment is not made. Such language shall be subject to Department review and approval.

The Contractor, via its electronic portal, shall accept and process Fast Track Payments made by credit card, debit card, pre-paid debit card, and electronic check. The Contractor's electronic portal shall provide the applicant a confirmation number upon the real-time processing of a

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payment. Additionally, the Contractor shall send a payment record in accordance with the Kentucky HEALTH Business Requirements, including, but not limited to inclusion of the payment date. Pursuant to the Kentucky HEALTH Business Requirements, the Contractor shall store the application identification number provided by IEES, the payment amount, and the payment date for the purpose of matching Fast Track Payments to HIPAA 834 records.

Upon receipt of the payment record for applicants who made a Fast Track Payment, IEES shall set the eligibility effective date as the first day of the month in which the Fast Track Payment was received by the Contractor. If no HIPAA 834 is received indicating the eligibility status of an applicant who has made a Fast Track Payment within sixty (60) days of the Contractor's original receipt of the Fast Track Payment, the Contractor shall issue a refund of the full amount within the next ten (10) business days.

If the applicant is determined eligible for Kentucky HEALTH as Cost Sharing Required or Cost Sharing Optional Enrollee, the Contractor shall calculate the difference between the Fast Track Payment made by the applicant and the actual premium obligation owed by the Enrollee as indicated on the HIPAA 834. The Enrollee's subsequent invoice shall display the following:

A. If the applicant's Fast Track Payment was made for a dollar amount more than the calculated premium amount as indicated on the HIPAA 834, the amount paid in excess of the premium shall be credited to the Enrollee's account, and the Enrollee's first invoice shall reflect the amount due as the calculated premium for the subsequent coverage month minus the amount of the excess Fast Track Payment.
B. If the applicant's Fast Track Payment was made for an amount less than the calculated premium amount as indicated on the HIPAA 834, the additional amount owed to complete the Enrollee's premium obligation shall be reflected on the Enrollee's first invoice, and the invoice shall reflect the amount due as the calculated premium for the subsequent coverage month plus the difference between the amount of the Fast Track Payment made and the total premium amount owed.

If the Contractor receives a HIPAA 834 with a matching Fast Track Payment indicator prior to the run cycle for Batch Invoicing on the fifteenth day of the month, the Contractor shall add the Enrollee to the batch scheduled on the fifteenth of the month during which the eligibility determination was made. If the Contractor receives a HIPAA 834 with a matching Fast Track Payment indicator after the Contractor's run cycle for Batch Invoicing on the fifteenth of the month, the Contractor shall send one (1) additional invoice to the Enrollee within three (3) business days of receiving the HIPAA 834. This Ad Hoc Invoice shall be due the first day of the following month. The Contractor shall then add the Enrollee to the Batch Invoicing for the following month.

If an applicant is determined Medicaid eligible but not as a Kentucky HEALTH Enrollee, or is enrolled as Cost Sharing Exempt, and no other Enrollee of the household is Cost Sharing Required or Cost Sharing Optional and enrolled with the Contractor, then the Contractor shall issue a refund of the full amount of the Fast Track Payment within ten (10) business days of receipt of the HIPAA 834 record indicating such eligibility. Additionally, if an applicant is determined eligible as a Former Foster Youth or Medically Frail Enrollee, the Contractor shall issue a refund of the Fast Track Payment if requested by the Enrollee. When a refund of a Fast Track Payment is made to a Cost Sharing Optional Enrollee, the Contractor shall transmit the refund information to the Department in accordance with the Kentucky HEALTH Business Requirements in order to facilitate Enrollee transition out of the Premium Plan without application of a Non-Payment Penalty. Refunds of Fast Track Payment shall be made to the original source of payment.

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42.4 Kentucky HEALTH Presumptive Eligibility

Individuals determined presumptively eligible for Kentucky HEALTH shall be enrolled with an MCO for the Presumptive Eligibility period. Presumptive Eligibility applicants shall be given the opportunity to select an MCO at the point of application. The Department shall assign the applicant in the absence of a self-selection.

The Contractor shall provide covered benefits during the Presumptive Eligibility period in accordance with the table below.

Category	Description	Presumptive Eligibility Benefits
PEAD	Presumptively Eligible ACA Expansion Enrollee	ABP (refer to Section 42.10)
PEPC	Presumptively Eligible Parent and Caretaker Relative	State Plan Benefits (refer to Section 31.0)
PEC1 **PEC2** **PEC4**	Presumptively Eligible Child	State Plan Benefits (refer to Section 31.0)
PEPR	Presumptively Eligible Pregnant Woman	Ambulatory Prenatal Care (as required under 42 CFR §435.1103)

The Contractor shall not send premium invoices during the Presumptive Eligibility period. Presumptively eligible ACA Expansion Enrollees and Parent and Caretaker Relatives shall be responsible for copayments for all services received during the Presumptive Eligibility period. The Contractor shall charge copayments to these Enrollees in accordance with Section 42.5.3 “Copayments” and deduct the applicable copayment amount from provider claims reimbursement.

The Presumptive Eligibility period shall end either (i) the last day of the month following the start of the Presumptive Eligibility period for individuals who do not file a Medicaid application; (ii) the day of the Medicaid application denial; or (iii) for individuals found fully eligible for Kentucky HEALTH, the first day of the month of the eligibility determination.

The HIPAA 834 shall contain information on presumptively eligible Enrollees who have been determined fully eligible for Kentucky HEALTH. ACA Expansion Enrollees and Parent and Caretaker Relatives transitioning from Presumptive Eligibility to fully eligible Kentucky HEALTH Enrollees shall be enrolled in the Copayment Plan initially, regardless of FPL, to provide sufficient time for the Enrollee to make a premium payment and avoid a coverage gap. Kentucky HEALTH Children, Former Foster Youth, Pregnant Women and Medically Frail Enrollees transitioning from Presumptive Eligibility to fully eligible Kentucky HEALTH Enrollees shall be enrolled in Kentucky HEALTH with no cost sharing requirement.

The Contractor shall send a prospective initial premium invoice within three (3) business days of receipt of a record on the HIPAA 834 indicating that the ACA Expansion Enrollee or Parent and Caretaker Relative Enrollee has transitioned from Presumptive Eligibility to the Copayment Plan. The invoice shall be due to be paid within sixty (60) days. The Contractor shall report invoice details to IEES in accordance with the Kentucky HEALTH Business Requirements. Enrollees transitioning from a Presumptive Eligibility period who do not make an initial premium payment within sixty (60) days of the invoice date shall be subject to a Non-Payment Penalty as outlined in Section 42.8.12 “Non-Payment of Premiums and Non-Payment Penalties.” If the Enrollee pays the invoice on or before its due date, the Contractor shall report the payment to IEES as part of its daily payment reporting, in accordance with the Kentucky HEALTH Business Requirements,

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which shall trigger conversion of the Enrollee to the Premium Plan effective the first day of the month following the month in which the payment was made. The Contractor shall then initiate ongoing Batch Invoicing as described in Section 42.8.1 “Batch Invoicing Obligations.”

42.5 Kentucky HEALTH Cost Sharing

42.5.1 Cost Sharing Obligations

All Kentucky HEALTH Enrollees shall be responsible for making financial contributions toward their health care coverage either through payment of premiums or copayments, except for the following groups:

Pregnant Women;

Kentucky HEALTH Children; and

Former Foster Youth and Medically Frail Enrollees, who may optionally pay premiums to gain access to the My Rewards Account.

42.5.2 Premiums

The Contractor shall impose monthly premiums in accordance with the premium amount reflected on the HIPAA 834 for all Conditionally Eligible and Premium Plan Enrollees. Premiums shall be calculated by the Department based on an enrollee’s MAGI household FPL. The Department shall have the right to adjust the premium amounts at any time and shall provide the Contractor at least sixty (60) days advance written notice of such adjustments becoming effective, after the initial premium. Initial premium amounts shall be charged as outlined in the table below. Kentucky HEALTH premiums shall be applied to the entire MAGI household enrolled with the Contractor. For example, if a husband and wife are both enrolled with the Contractor, and their combined income is below twenty-five percent (25%) FPL, a total monthly premium of one dollar ($1.00) shall be charged to the household by the Contractor. Kentucky HEALTH MAGI households with a premium obligation who are enrolled with multiple MCOs shall be charged a premium for each MCO with which they are enrolled. For example, if a husband and wife are enrolled in separate MCOs and their income is below twenty-five percent (25%) FPL, each MCO with which they are enrolled shall charge a one dollar ($1.00) monthly premium.

FPL	Monthly Premium Amount
≤25% FPL	$1.00
>25% - ≤50%	$4.00
>50% - ≤100%	$8.00
>100% - ≤138%	$15.00

For Kentucky HEALTH Enrollees with an income above one hundred percent (100%) FPL, premiums shall increase based on length of enrollment in Kentucky HEALTH. The duration of enrollment shall be calculated based on the Kentucky HEALTH Enrollee within a MAGI household with the longest enrollment in Kentucky HEALTH. The Contractor shall charge escalating premiums in accordance with the table below.

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Duration of Kentucky HEALTH Enrollment	Monthly Premium
0-24 months	$15.00
25-36 months	$22.50
37-48 months	$30.00
49+ months	$37.50

The Contractor shall accommodate the premium schedule in accordance with any future modifications made by the Department. The Department shall provide sixty (60) days advanced notice to the Contractor of any such modifications.

42.5.3 Copayments

The Contractor shall impose copayment requirements on all Copayment Plan Enrollees. The copayment schedule shall be the copayments approved by CMS in the Kentucky Medicaid State Plan. The Contractor shall update the copayment schedule in accordance with any future modifications made by the Department. The Department shall provide sixty (60) days advanced notice to the Contractor of any such modifications.

The Contractor shall establish education efforts, policies, and procedures for contracted providers to collect copayments from Kentucky HEALTH Enrollees enrolled in the Copayment Plan at the time of service. In accordance with 42 CFR §447.52, providers shall not deny care or services to any Enrollee at or below one hundred percent (100%) FPL because of his or her inability to pay the copayment. The Contractor shall implement the following mechanisms to enforce this policy: (i) provider education; (ii) documentation in the provider manual; and (iii) assistance to Enrollees who report that they have been denied services due to inability to pay.

Additionally, the Contractor shall reduce the payment it makes to providers by the amount of the Enrollee's copayment obligation, regardless of whether the provider has collected the payment. The Contractor shall ensure that copayments are not imposed on the following exempt services:

1. Emergency Services as defined at Section 1932(b)(2) of the Social Security Act and 42 CFR §438.114(a);
2. Family planning services and supplies described in Section 1905(a)(4)(C) of the Social Security Act, including contraceptives and pharmaceuticals for which the State can claim enhanced federal match under Section 1903(a)(5) of the Social Security Act;
3. Preventive Services, defined as (i) all the preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF); or (ii) all approved adult vaccines, including their administration, recommended by the Advisory Committee on Immunization Practices, as well as the influenza vaccine; or (iii) preventive care and screening recommended by the Health Resources and Services Administration Bright Future Program Project; or (iv) preventive services recommended by the Institute of Medicine;
4. Pregnancy-related services, which in accordance with 42 C.F.R. 447.56 shall include all services provided to pregnant Kentucky HEALTH Enrollees; and
5. Provider-preventable services as defined in 42 CFR §447.26(b).

In imposing a copayment for an emergency room visit for a non-emergent service, the

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Contractor shall ensure compliance with 42 CFR §447.54 and Section 42.11 "Non-Emergency Use of the Emergency Room". The Contractor shall consider an emergency room visit emergent, for purposes of waiving the copayment, if the Enrollee had a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the Enrollee (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

The Contractor shall not limit what constitutes a non-emergent visit, for purposes of imposition of the copayment, on the basis of lists of diagnoses or symptoms. Conditional Eligibility, Initial Invoicing, and Payment Processing

42.6 Conditional Eligibility, Initial Invoicing, and Payment Processing

42.6.1 Conditional Eligibility Welcome Packet and Initial Invoicing

Within three (3) business days of receipt of a HIPAA 834 with a new Conditionally Eligible Enrollee, the Contractor shall send a Kentucky HEALTH welcome packet. The Kentucky HEALTH welcome packet shall include, at minimum, an initial premium invoice and a welcome letter. The Contractor's welcome packet shall be subject to Department review and approval in accordance with Section 4.4 "Approval of Department."

The initial premium invoice shall meet the requirements of Section 42.8.1 "Batch Invoicing Obligations." Additionally, it shall include: (i) a clear indication that benefit coverage is conditioned upon premium payment, including a description of how the benefit effective date is impacted by premium payment; and (ii) that the individual may change MCOs until the first payment is made, including clarification that once initial payment is made, the Enrollee may only change MCOs for cause, except during the annual open enrollment period.

The welcome letter shall be tailored individually to address differences for households with income at or below one hundred percent (100%) FPL, and those with income above one hundred percent (100%) FPL. The welcome letter shall include the following:

A. An explanation that payment is due sixty (60) days from the date of first invoice;
B. An explanation that eligibility shall be effective the first day of the month during which a timely payment is made;
C. An explanation of the consequences of non-payment, which shall be as follows:
    1. For households with income at or below one hundred percent (100%) FPL, the letter shall explain that if an initial premium payment is not received within sixty (60) calendar days of the invoice date, coverage in the Copayment Plan shall begin the first day of the month in which the sixty (60) day payment period ends. Further, it may describe the benefits of enrollment in the Premium Plan versus Copayment Plan, including, but not limited to, predictability in healthcare costs and access to the My Rewards Account; and
    2. For households with income above one hundred percent (100%) FPL, the letter shall indicate that failure to make an initial premium payment within sixty (60) days of the invoice date shall result in denial of eligibility and the requirement to reapply for Kentucky HEALTH coverage;
D. A description of the option to change the Enrollee's MCO before payment is made and how to do so;

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E. Information about requirements for reporting any changes that may impact eligibility;
F. An explanation that once initial payment is made, an Enrollee may only change MCOs for cause, except during the annual open enrollment period.

The Contractor shall invoice Conditionally Eligible Enrollees experiencing transitions or changes in accordance with Kentucky HEALTH Business Requirements. Transitions which may occur during the conditional eligibility period which impact Contractor invoicing include, but are not limited to (i) case changes; (ii) Medically Frail determinations; (iii) pregnancy reports; and (iv) MCO changes.

42.6.2 Conditional Eligibility Initial Invoice Reporting

The Contractor shall send conditionally eligible invoice information to IEES daily and in accordance with the Kentucky HEALTH Business Requirements.

42.6.3 Conditional Eligibility Reporting of Payment and Non-Payment

The Contractor shall report payments received from Conditionally Eligible Enrollees on a daily basis to IEES. The Contractor shall report the payment date as the date of receipt; however, payment records shall only be sent after the payment has cleared. Notwithstanding the foregoing, the Contractor shall ensure the timely processing of payments and shall send payment records to IEES within one (1) business day of the payment clearing and no later than the sixth day of the month following receipt of payment. The Conditionally Eligible Enrollee shall become fully eligible for Kentucky HEALTH effective the first day of the month of the reported premium payment date. The Contractor shall transition Conditionally Eligible Enrollees who become fully eligible for Kentucky HEALTH to ongoing Batch Invoicing in accordance with Kentucky HEALTH Business Requirements.

Once the Contractor has confirmed from all payment sources that payment was not received by the due date (sixty (60) days following the date of invoice), the Contractor shall send IEES a termination record indicating the Enrollee's late payment. When either a late payment is reported, or no record is sent by the Contractor within seventy-five (75) days of the initial eligibility determination date, the Conditionally Eligible Enrollee shall be subject to non-payment penalties in accordance with Section 42.6.5 "Non-Payment Penalty During Conditional Eligibility."

If the Contractor receives a payment of an initial invoice following the close of the sixty (60) day payment period, the payment shall not be reported to IEES as payment of the initial invoice. Rather, for individuals in households with income at or below one hundred percent (100%) FPL, the Contractor shall retain the payment and apply it to a future invoice. For individuals in households with income above one hundred percent (100%) FPL, the Contractor shall refund the payment within thirty (30) days of receipt.

42.6.4 Conditional Eligibility Payment Reminders

The Contractor shall send a minimum of two (2) written payment reminder notices to Conditionally Eligible Enrollees between the date of initial invoice and the close of the sixty (60) day payment period. Payment reminders shall not be required once payment of the initial invoice is made. The intervals by which these payment reminders are sent shall be at the discretion of the Contractor. The Contractor's payment reminder notices shall be subject to Department review and approval in accordance with Section 4.4 "Approval of Department."

42.6.5 Non-Payment Penalty During Conditional Eligibility

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Conditionally Eligible Enrollees shall make a premium payment within sixty (60) days of the Contractor's invoice date. IEES shall determine Conditionally Eligible Enrollees' payment as untimely upon the first of (i) receipt of the Contractor's non-payment file; or (ii) passage of seventy-five (75) days since the Enrollee was determined eligible for Kentucky HEALTH.

Conditionally Eligible Enrollees over one hundred percent (100%) FPL who fail to make a premium payment within sixty (60) days of the invoice date shall be denied eligibility for Kentucky HEALTH. A Conditionally Eligible Enrollee over one hundred percent (100%) FPL who has previously been denied eligibility for Kentucky HEALTH shall submit a new application should they wish to participate in Kentucky HEALTH, and no non-payment penalty shall be applied. The Contractor shall have no ongoing responsibilities to a formerly Conditionally Eligible Enrollee who has been denied eligibility for Kentucky HEALTH. Notwithstanding the foregoing, if the Contractor has received a partial payment from the Conditionally Eligible Enrollee that does not satisfy the individual's full premium obligation, the Contractor shall issue a refund of the partial payment within thirty (30) days.

Conditionally Eligible Enrollees at or below one hundred percent (100%) FPL who fail to make a premium payment within sixty (60) days of the invoice date shall be enrolled in the Copayment Plan effective the first day of the month in which the sixty (60) day payment period expires. The Enrollee shall then receive a six (6) month Non-Payment Penalty effective the first of the next administratively feasible month.

42.7 Kentucky HEALTH Enrollment Materials

Within five (5) business days of receipt of a HIPAA 834 record indicating enrollment of a fully eligible Kentucky HEALTH Enrollee, the Contractor shall issue a Kentucky HEALTH Enrollee identification card.

The Enrollee identification card shall include, at minimum, the following components:

A. The Kentucky HEALTH Enrollee's name and identification number;
B. The Contractor's Enrollee services call center phone number;
C. The Contractor's nurse hotline phone number, which shall be operable twenty-four (24) hours per day, seven (7) days per week;
D. The Contractor's provider call center phone number;
E. The Contractor's website; and
F. The Kentucky HEALTH logo.

To account for potential movement between the Premium Plan and Copayment Plan, the Enrollee identification card shall not include an indication of the cost sharing plan in which the Kentucky HEALTH Enrollee is enrolled.

Additionally, in accordance with Section 23.2 "Enrollee Handbook," the Contractor shall deliver to Kentucky HEALTH Enrollees an Enrollee handbook within five (5) business days of receipt of a HIPAA 834 fully eligible add record. In addition to the general Enrollee handbook requirements described in Section 23.2 "Enrollee Handbook," the Enrollee handbook shall include, at minimum, the following Kentucky HEALTH information:

A. Cost sharing requirements, including consequences for non-payment;
B. My Rewards Account overview, including information on how to accrue funds and policies pertaining to deductions;
C. Instructions regarding how to request a Medically Frail determination;
D. Community Engagement requirements;
E. Requirements for early re-entry and curing penalties for premium non-payment, Community

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Engagement and recertification non-compliance, voluntary withdrawal, and penalties for failure to report a change;

F. Description of vision and dental benefits available through the My Rewards Account versus directly through the Contractor; and
G. An overview of the Deductible Account.

The Contractor's Enrollee identification card and Enrollee handbook shall be subject to Department review and approval in accordance with Section 4.4 "Approval of Department." Additionally, the Department shall have the right to establish guidelines regarding the use of the Kentucky HEALTH logo; with which the Contractor shall comply. The Contractor may establish a separate supplement for Kentucky HEALTH to be included with the Enrollee Handbook.

42.8 Billing and Collections

The Contractor shall operate billing and collection services for Kentucky HEALTH which include, at minimum, the following key components:

A. Generating invoices available in the format requested by the Kentucky HEALTH Enrollee in accordance with Section 42.8.1 "Batch Invoicing Obligations;"
B. Receiving and reporting premium payments;
C. Monitoring and tracking missed premium payments;
D. Processing returned checks;
E. Generating delinquent payment notices;
F. Providing documentation of premium payment activities and other related financial reports in the timeframe and format requested by the Department;
G. Processing electronic Fast Track Payments in accordance with Section 42.3 "Fast Track Enrollment;"
H. Providing documentation and reconciliation of premium payments received;
I. Providing Enrollees the opportunity to review and seek correction of their payment history;
J. Maintaining premium collection system that identifies, validates, and provides reasonable modifications related to the obligation to pay premiums to Enrollees with disabilities protected by the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act; and
K. Complying with the requirements of the Kentucky HEALTH STCs.

In operating billing and collection services, the Contractor shall not pass along to Enrollees any costs associated with the processing of payments or collecting past-due payments.

42.8.1 Batch Invoicing Obligations

The Contractor shall develop and send ongoing Batch Invoices for Kentucky HEALTH Enrollees enrolled in the Premium Plan.

The Contractor shall provide Enrollees the option to receive invoices electronically as an alternative to paper. The Contractor shall mail invoices with a detachable payment coupon and a return envelope without postage paid to all Enrollees that do not elect to receive invoices electronically.

The Contractor shall submit the invoice template to the Department for review and approval in accordance with Section 4.4 "Approval of Department." The Contractor invoice shall be developed at a sixth (6th) grade reading level in a font no smaller than twelve (12) point. The Contractor shall send invoices in Spanish to households for whom the HIPAA 834 indicates Spanish as the primary household language. The Contractor shall also translate invoices to

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each prevalent non-English language. The invoice shall include, at minimum, the following information:

A. The Contractor's name, even if the Contractor subcontracts the invoicing function;
B. First name, last name, and address of the Head of Household to whom the invoice is being sent;
C. First and last name(s) of the Kentucky HEALTH Enrollee(s) enrolled with the Contractor to whom the premium applies with an indication that the family premium applies to each MCO with which the family is enrolled;
D. First and last name of the Kentucky HEALTH Enrollee(s) enrolled with the Contractor within the household who currently have a Kentucky HEALTH penalty period or suspension status;
E. The invoice amount, which clarifies the monthly premium contribution plus any amounts Past Due;
F. Any applicable overpayments shown as a credit;
G. Invoice due date;
H. Non-payment consequences;
I. Notification of all forms of payment accepted by the Contractor as outlined in Section 42.8.4 "Payment Methods;"
J. Inclusion of a Department-developed insert or language provided by the Department which details instructions on how to report a change in household composition or monthly income, including the deadline for reporting changes and consequences for failure to report a change in a circumstance that may affect eligibility;
K. Indication that once payment is made, a change in MCO is permitted only for cause or during the annual open enrollment period;
L. Contractor contact information for questions or concerns regarding the premium payment or invoice, including the Contractor's Enrollee call center and TTY-TDD telephone number;
M. A tagline in compliance with 42 CFR §438.10 written in the prevalent non-English languages spoken by at least five percent (5%) of the Contractor's Kentucky HEALTH population and in font no smaller than eighteen (18) point that explains the availability of written translation or oral interpretation to understand the information provided;
N. Clear indication on invoices for Medically Frail and Former Foster Youth Enrollees that the premium obligation is optional, including consequences for non-payment;
O. Detachable portion, on paper invoices, identifying case number to which the invoice applies, which can be returned with payment; and
P. Any additional information as directed by the Department.

Batch Invoices shall reflect the next full month of coverage. The Contractor shall send ongoing monthly premium invoices no later than the fifteenth of each month with a due date of the first day of the following month.

The Head of Household shall be indicated on the HIPAA 834; however, the Contractor shall permit a household to designate a different primary responsible payer to whom invoices shall be sent.

42.8.2 Invoice Reporting Obligations

The Contractor shall send invoice information to IEES monthly, and in accordance with the Kentucky HEALTH Business Requirements, for ongoing monthly premium invoices.

42.8.3 Invoicing Medically Frail and Former Foster Youth

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Individuals known to be Medically Frail at the time of Medicaid application and Former Foster Youth shall be Cost Sharing Optional upon enrollment with the Contractor. These Enrollees shall be given the opportunity to opt into the Premium Plan to gain access to the My Rewards Account. The Contractor shall invoice Cost Sharing Optional Enrollees within three (3) business days of receipt of the HIPAA 834 reflecting initial enrollment with the Contractor. Unless there are Cost Sharing Required Enrollees in the household, the Contractor shall ensure the invoice clearly indicates that the premium payment is optional. For cases in which there are no Cost Sharing Required Enrollees in the household, the Contractor shall send a welcome letter with the invoice containing, at minimum, the following information: (i) that payment is optional; and (ii) that a premium payment shall give the Enrollee access to the My Rewards Account.

If the Cost Sharing Optional Enrollee opts not to pay the premium within sixty (60) days of the initial invoice, the Enrollee shall be considered to have opted out of premium payments. No Non-Payment Penalty shall be applied to Medically Frail or Former Foster Youth who choose not to make premium payments. The Contractor shall not be required to continue invoicing Cost Sharing Optional Enrollees who have opted out of premium payments. However, the Contractor shall develop an outreach program, subject to Department approval, targeted to Cost Sharing Optional Enrollees to assist them in learning about the benefits of the Premium Plan. This outreach shall include, at minimum, requirements for accessing the Premium Plan and benefits of the Premium Plan, including but not limited to access to the My Rewards Account.

42.8.4 Payments Methods

The Contractor shall accept, at minimum, premium payments via the following methodologies:

A. Check;
B. Money order;
C. Automatic payroll deduction;
D. Cash;
E. Online payment via web portal;
F. Electronic check or debit card payment via telephone;
G. Automatic draft withdrawal from a designated account;
H. Credit and debit card;
I. Automated Clearinghouse (ACH); and
J. Electronic funds transfer.

The Department encourages the Contractor to establish arrangements for Kentucky HEALTH Enrollees to make no-cost premium payments at in-person locations, particularly via cash. To the extent such arrangements are utilized, the Contractor shall ensure that any in-person contributions are processed and communicated to IEES in accordance with the timelines and requirements established at Section 42.8.5 “Payment Processing and Reporting.”

42.8.5 Payment Processing and Reporting

The Contractor shall communicate all information regarding premium payments to IEES in accordance with the Kentucky HEALTH Business Requirements. This shall include, but shall not be limited to, transmission of the Contractor invoice date for each Kentucky HEALTH Enrollee with a premium obligation, premium payments received, and the date of payment receipt. The Contractor shall transmit records of all premium payments and non-payments for ongoing Batch Invoicing no later than the sixth day of each month.

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For premium payments via direct deposit or payroll deduction, the Contractor shall provide confirmation to the Enrollee that the payment was debited. Additionally, for electronic and telephonic payments, the Contractor shall provide the Enrollee with a confirmation number upon real-time processing of the payment.

The Contractor shall make premium payment status available to its Enrollees (i.e., via an Enrollee web portal or helpline). Available information shall include, but not be limited to, the Enrollee's required monthly premium contribution amount, a record of premium payments received year-to-date, and Past Due premium payment amounts. The Contractor shall give Enrollees an opportunity to review and seek correction of their payment history.

Payment via a dishonored check due to insufficient funds shall be considered non-payment. If an Enrollee's check is returned for insufficient funds, the Contractor may charge a commercially reasonable fee for the returned check. However, any Enrollee non-payment of the returned check fee shall be considered Debt and under no circumstances shall the Contractor be permitted to treat such non-payment as Past Due. The Contractor shall develop, print, and mail notices to Enrollees if their payments are returned from the bank due to insufficient funds. These notices shall be subject to Department review and approval in accordance with Section 4.4 "Approval of Department," and shall include, at minimum, notification that the premium payment could not be processed due to insufficient funds, the premium amount due, the due date, and consequences for non-payment.

The Contractor shall accept partial premium payments. However, the Kentucky HEALTH Enrollee shall pay the monthly premium payment in full, and all other amounts due, within sixty (60) calendar days of the invoice date or be subject to a Non-Payment Penalty described in Section 42.8.12 "Non-Payment of Premiums and Non-Payment Penalties."

As such, the Contractor shall track partial payments of premiums, but shall only send a payment record to IEES after the complete premium payment has cleared.

The Contractor shall also accept pre-payments of future premium contributions. The Contractor shall track such payments as a credit toward future premium payments. The Contractor shall continue to send monthly Batch Invoices when prepayments have been made; the invoice shall reflect the premium amount due with any prepayment listed as a credit applied to the premium.

42.8.6 Delinquent Payment Notices

If an Enrollee has not made the required premium payment for the current month of coverage, the Contractor shall send the Enrollee a delinquent payment notice. The first notice may be sent as early as the second day of the month of coverage for which payment has not been received and shall be sent no later than the seventh day of the month of coverage for which the premium payment was to be applied. If the Contractor does not receive a premium payment from an Enrollee for a second consecutive month, a second delinquent payment notice shall be sent. This notice may be sent as early as the second day of the second unpaid coverage month and shall be sent no later than the seventh day of the second coverage month of non-payment.

The Contractor shall develop three (3) separate delinquent payment notices targeted to: (i) individuals at or below one hundred percent (100%) FPL; (ii) individuals above one hundred percent (100%) FPL; and Cost Sharing Optional Enrollees who have opted into premium payments. The notice targeted by FPL shall include an explanation noting a change in income moving the Enrollee above or below one hundred percent (100%) FPL will impact the type of Non-Payment Penalty applied. These notices shall advise the Enrollee of (i) the

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delinquent payment; (ii) the date that the payment shall be made to prevent a Non-Payment Penalty; (iii) the option for Medically Frail screening; (iv) consequences of nonpayment of required premiums; and (v) information about reporting changes in circumstances, including household income. The notice targeted to households with only Cost Sharing Optional Enrollees shall indicate that the Enrollee shall no longer have access to the My Rewards Account if payment is not received.

The Contractor's delinquent payment notices are subject to Department review and approval in accordance with Section 4.4 "Approval of Department."

42.8.7 Invoicing and Outreach During Kentucky HEALTH Penalty and Suspension Periods

The Contractor shall not be required to invoice Enrollees who have been assessed a Non-Payment Penalty. However, the Contractor shall conduct outreach to these Enrollees, in accordance with a Contractor-developed and Department-approved outreach strategy. At a minimum, as part of its outreach strategy, the Contractor shall correspond to the Enrollee in writing during the month in which the penalty is effectuated, which shall include details necessary to facilitate Enrollee payment. This communication shall include, at a minimum: (i) how to remove the Non-Payment Penalty; (ii) amount of premium owed; (iii) forms of payment accepted; (iv) where payment can be made; and (v) the overall benefits of Kentucky HEALTH, including the benefits of participating in the Premium Plan for individuals on the Copayment Plan.

Notwithstanding the foregoing, the Contractor shall send a premium invoice on the fifteenth of the month prior to the end of an Enrollee's Non-Payment Penalty period. This invoice shall include a cover letter indicating that the Enrollee's penalty period is ending and the Enrollee need only make one (1) premium payment to enter the Premium Plan and regain access to the My Rewards Account. The invoice shall only require payment of the upcoming coverage month.

The Contractor shall not invoice Enrollees in a Community Engagement Suspension. However, the Contractor shall develop an outreach program approved by the Department to assist such Enrollees in regaining coverage. At a minimum, this outreach shall include requirements for ending the Community Engagement Suspension and the overall benefits of Kentucky HEALTH.

42.8.8 Invoicing During Kentucky HEALTH Transition Scenarios

The Contractor shall follow Kentucky HEALTH Business Requirements for invoicing Enrollees under any of the following transition scenarios: (i) from Cost Sharing Optional to Cost Sharing Required; (ii) from Cost Sharing Exempt to Cost Sharing Required; and (iii) from Cost Sharing Required to Cost Sharing Optional.

42.8.9 Third Party Payment of Premiums

Third parties are permitted to contribute toward a Kentucky HEALTH Enrollee's premium up to one hundred percent (100%) of the Enrollee's monthly premium obligation. The Contractor shall credit third party contributions to the Enrollee's balance upon receipt and may not use the contribution for any other purpose.

If a third party contributes more than one (1) month premium payment, the Contractor shall treat the excess funds as a prepayment, tracking the overpayment as a credit toward future

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premium payments. The Contractor shall continue to send the Enrollee an ongoing Batch Invoice on the fifteenth day of each month, with the prepayment listed as a credit.

Any third party contributions that exceed an Enrollee's total premium obligation for the remainder of the Benefit Year shall be returned by the Contractor to the contributing third party within thirty (30) days of receipt.

The Contractor shall ensure healthcare providers or provider-related entities making premium payments on behalf of Kentucky HEALTH Enrollees have criteria for providing assistance that does not distinguish between Enrollees based on whether or not they will receive services from the contributing provider(s) or class of provider(s). Further, the Contractor shall ensure that contributing providers do not include the cost of Kentucky HEALTH premium contributions in the cost of care for purposes of Medicare and Medicaid cost reporting or as part of a Medicaid shortfall or uncompensated care.

The Contractor shall maintain a record of all contributions made by third parties on behalf of Enrollees and make reports available to the Department in the timeframe, frequency and format requested. The Contractor shall not make any premium contribution on behalf of a Kentucky HEALTH Enrollee. Further, the Contractor shall be prohibited from reducing the premium amount below the limits established by the Department as described in Section 42.5.2 "Premiums."

42.8.10 Premium Recalculations

Enrollees shall report to the Cabinet all changes which may affect eligibility and their required premium contribution, including changes in income and family size. The Department shall notify the Contractor, via the HIPAA 834, of changes to premium amounts as a result of reported changes. The Contractor shall begin invoicing Kentucky HEALTH Enrollees the updated premium amount in the billing cycle in which the change is effective. If the Contractor receives the change in premium amount after the monthly invoice has already been sent, the amount shall be adjusted on the next month's premium invoice. If the premium payment received after the adjusted premium amount is effective exceeds the new monthly premium obligation, the Contractor shall apply the surplus amount as a credit toward future months' premiums. If the premium payment received after the adjusted premium amount is effective is less than the new monthly premium obligation, the Contractor shall add the remaining balance to the Enrollee's next monthly invoice.

42.8.11 Premium Refunds

If an individual makes a premium payment following termination of enrollment or transfer to another MCO, the Contractor shall apply the payment to any Past Due amounts or Debt owed to the Contractor by the individual. If there are no Past Due amounts or Debt, Contractor shall refund the payment to the individual. If the payment exceeds the Past Due or Debt amount, the Contractor shall apply the payment to the Past Due or Debt amount and refund to the individual any remaining credit. Such refunds shall be made to the individual within thirty (30) days of the last date of the Enrollee's participation with the Contractor. The Contractor shall report payment of Past Due amounts and refunds to IEES. The Contractor shall not report the terminated individual's payment as a payment toward a future month of coverage.

If an Enrollee makes a payment while in a suspended status, the Contractor shall apply the payment in accordance with Kentucky HEALTH Business Requirements. However, if a suspended individual requests a refund of an advanced payment, the Contractor shall refund the payment within thirty (30) days of the request.

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In accordance with 42 CFR §447.56, Pregnant Women shall be Cost Sharing Exempt. Enrollees are required to report changes, including pregnancy; therefore, the Contractor is not obligated to retroactively refund premiums paid for months prior to Contractor identification or Kentucky HEALTH Enrollee self-report of pregnancy. The Contractor shall implement strategies to educate Enrollees on the requirement to report pregnancy to the Cabinet. However, once the Contractor is aware of a Kentucky HEALTH Enrollee's pregnancy, the Contractor shall ensure that no premiums are imposed on the pregnant Enrollee. Therefore, in the event that the Contractor has received a prospective premium payment from a woman who is subsequently identified as pregnant, the Contractor shall refund the premium payment for the future month of coverage, within thirty (30) days of the notification of pregnancy. Notwithstanding the foregoing, the Contractor shall apply the premium payment to the Enrollee's premium obligation at the end of her sixty (60) day post-partum period, if that is the preference indicated by the Enrollee. Additionally, the Contractor shall not refund the payment if there are household Enrollees also enrolled in the Premium Plan with the Contractor as the Kentucky HEALTH premium payment is a family premium payment.

42.8.12 Non-Payment of Premiums and Non-Payment Penalties

If a Cost Sharing Required Enrollee fails to make a premium payment by the due date of an ongoing Batch Invoice, the Contractor shall send a non-payment file no later than the sixth day of the month. There shall be no immediate consequence to an Enrollee the first time they are sent in a non-payment status on the Contractor's monthly payment status file. If an Enrollee is included on a second consecutive non-payment file from the Contractor, a Non-Payment Penalty shall become effective the first day of the following month if the Enrollee does not ensure that all owed payments are up-to-date prior to the penalty effective date.

The Non-Payment Penalty for Enrollees whose household income is over one hundred percent (100%) FPL shall be suspension from Kentucky HEALTH enrollment. Kentucky HEALTH Enrollees with income at or below one hundred percent (100%) FPL shall be enrolled in the Copayment Plan. Under the Copayment Plan, Enrollees shall be subject to a copayment for every Kentucky HEALTH service received, as outlined in Section 42.5.3 "Copayments." Additionally, the Department shall deduct twenty-five dollars ($25) from the Enrollee's My Rewards Account. The My Rewards Account shall also be suspended for the duration of the Enrollee's enrollment in the Copayment Plan, and the Enrollee shall be unable to either use funds from the account or accrue funds in the account for services or activities completed during the suspension.

The Contractor shall report any payments received by the Enrollee to cure the Non-Payment Penalty before it is effectuated, and in accordance with the Kentucky HEALTH Business Requirements. If the Enrollee makes payment prior to the end of the month before the Non-Payment Penalty effective date, but with insufficient time for the Contractor to send a payment record which voids the Non-Payment Penalty prior to it taking effect, the following shall occur:

A. Enrollees with an income at or below one hundred percent (100%) FPL who were moved to the Copayment Plan shall be moved to the Premium Plan effective the first day of the following month to avoid retroactively overlaying coverage. The Contractor shall invoice these Enrollees during the Batch Invoicing cycle on the fifteenth day of the month to reflect the premium due for the following month of coverage in the Premium Plan.
B. Enrollees with income over one hundred percent (100%) FPL whose enrollment was suspended shall be enrolled in the Premium Plan effective the first day of the month with no gap in coverage. The Contractor shall continue invoicing the Enrollee on the Batch Invoicing cycle.

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The Contractor shall wait until receipt of a HIPAA 834 record to take any actions associated with the Non-Payment Penalty, including suspension or movement from the Premium Plan to the Copayment Plan.

Notwithstanding the foregoing, the following Kentucky HEALTH Enrollees shall not be subject to a Non-Payment Penalty: (i) Cost Sharing Optional Enrollees; and (ii) Enrollees determined to have good cause for non-payment as described in Section 42.8.13 "Good Cause for Premium Non-Payment."

A Non-Payment Penalty shall remain effective for six (6) months unless the Kentucky HEALTH Enrollee (i) completes early re-entry requirements outlined in Section 42.8.14 "Non-Payment Early Re-Entry;" (ii) has a good cause for non-payment; or (iii) during the penalty period becomes pregnant, is determined to be Medically Frail, or otherwise becomes eligible for Medicaid under an eligibility group not subject to a Non-Payment Penalty.

In the absence of early re-entry, the Contractor shall send one (1) premium invoice the month before the expiration of the Enrollee's Non-Payment Penalty. The invoice shall include a cover letter indicating that the Enrollee's Non-Payment Penalty is ending and that the Enrollee shall make at least one (1) prospective premium payment to transition back to the Premium Plan and regain access to the My Rewards Account. The Contractor may still pursue collection of Debt in accordance with Section 42.8.16 "Debt Collection." Upon expiration of the Non-Payment Penalty, the effective date of an Enrollee's transition from the Copayment Plan to the Premium Plan shall be the first day of the month following premium payment. The effective date of an Enrollee's transition from a suspended status to the Premium Plan shall be the first day of the month in which the premium payment is made.

Enrollees with income at or below one hundred percent (100%) FPL who opt not to make a premium payment at the close of the Non-Payment Penalty period shall remain enrolled with the Contractor in the Copayment Plan with no additional Non-Payment Penalty. Suspended Enrollees with income above one hundred percent (100%) FPL who opt not to make a premium payment at the close of the Non-Payment Penalty period shall remain suspended. The Contractor shall continue outreach to these Enrollees in accordance with Section 42.8.7 "Invoicing and Outreach During Kentucky HEALTH Penalty and Suspension Periods."

42.8.13 Good Cause for Premium Non-Payment

An Enrollee who fails to make the required premium payment for any of the following reasons shall not be subject to a Non-Payment Penalty:

A. The Enrollee is hospitalized or otherwise incapacitated, or has a disability as defined by the ADA, Section 504 of the Rehabilitation Act, or Section 1557 of the Affordable Care Act, and as a result is unable to pay premiums during the entire sixty (60) day payment period; has a disability and was not provided with reasonable modifications needed to pay the premium; or has a disability, and there were no reasonable modifications which would have enabled the Enrollee to pay premiums during the entire sixty (60) day payment period;
B. An individual in the Enrollee's immediate family who was living in the same home as the Enrollee was institutionalized or died during the sixty (60) day payment period; an immediate family Enrollee living in the same home as the Enrollee has a disability as defined by the ADA, Section 504 of the Rehabilitation Act, or Section 1557 of the Affordable Care Act, and caretaking or other disability-related responsibilities resulted in the Enrollee's inability to pay the premiums;
C. The Enrollee was evicted from his or her home or experienced homelessness during the sixty (60) day payment period;

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D. The Enrollee was the victim of a declared natural disaster, such as a flood, storm, earthquake, or serious fire, that occurred during the sixty (60) day payment period; or
E. The Enrollee was a victim of domestic violence during the sixty (60) day payment period.

The Contractor shall be responsible for educating Enrollees on the good cause reasons for premium non-payment as outlined in paragraphs A through E of this subsection, as well as the process for reviewing and processing premium non-payment good cause requests. Kentucky HEALTH Enrollees may report good cause for premium non-payment to the Cabinet or the Contractor. If the report is made to the Contractor, the Contractor shall complete the following:

A. Gather the good cause reason reported by the Enrollee;
B. Determine if the reported reason is in alignment with the non-payment good cause reasons outlined in paragraphs A through E of this subsection;
C. Determine how many months, and for which months, the good cause reason applies. If a good cause reason only applies to one (1) month, the Contractor shall log the good cause reason for the one (1) month;
D. Inform the Enrollee of the obligation to provide verification to the Cabinet, the acceptable forms of verification, and the process for submission; and
E. Send the file to IEES with premium non-payment good cause records in accordance with the Kentucky HEALTH Business Requirements.

The Contractor shall continue to invoice Enrollees with a pending good cause request during the ongoing Batch Invoicing schedule. Because only verified good cause reasons shall be accepted, and these must be reviewed and confirmed by the Cabinet, the Contractor shall continue to invoice the Enrollee and reflect non-payments as Past Due until receipt of verification from the Department that the good cause request has been approved. The Contractor may collect any Debt owed as a result of the good cause non-payment; however, the unpaid amounts shall be considered a Debt owed, rather than a Past Due amount that is required in order to avoid a penalty.

42.8.14 Non-Payment Penalty Early Re-Entry

Kentucky HEALTH Enrollees subject to a Non-Payment Penalty may re-enter the Premium Plan prior to the expiration of the six (6) month penalty period by completing early re-entry requirements. These early re-entry requirements shall include: (i) payment of any applicable Past Due premium amounts; (ii) payment of one (1) month's future premium payment; and (iii) completion of a Re-Entry Course. Enrollees may only exit the Non-Payment Penalty period once during any Benefit Year.

The Contractor shall not be responsible for providing Re-Entry Courses. Rather, the Contractor shall implement outreach and communication strategies to Enrollees in a Non-Payment Penalty period as described in Section 42.8.7 "Invoicing and Outreach During Kentucky HEALTH Penalty and Suspension Periods." Additionally, the Contractor shall ensure that its call center staff are prepared to answer inbound calls from Enrollees in a Non-Payment Penalty period with information regarding the requirements for early re-entry.

42.8.15 4% Maximum Cost Sharing

In accordance with the Special Terms and Conditions and 42 CFR §447.56, a Kentucky HEALTH Enrollee's total cost sharing shall not exceed four percent (4%) of the Enrollee's MAGI household income applied on a quarterly basis. Upon receipt of a HIPAA 834 file indicating that a Kentucky HEALTH Enrollee has reached the four percent (4%) cost sharing limit, for Kentucky HEALTH Enrollees in the Copayment Plan, the Contractor shall ensure

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that copayments are no longer collected from the Enrollee and are not deducted from provider claims reimbursement through the end of the calendar quarter. For Kentucky HEALTH Enrollees enrolled in the Premium Plan, the Contractor shall send monthly premium invoices reflecting a premium obligation of one dollar ($1.00) for the remainder of the calendar quarter. In the event that a Kentucky HEALTH Enrollee made a premium payment in excess of one dollar ($1.00) after the five percent (5%) limit has been met, the Contractor shall apply the amount paid over one dollar ($1.00) to a future coverage month and reflect the credit on the next invoice. The Contractor shall process updated HIPAA 834 files reflecting the reinstatement of cost sharing for the next calendar quarter and begin charging copayments and premiums in accordance with Kentucky HEALTH policies as outlined in this Contract.

42.8.16 Debt Collection

The Contractor may pursue unpaid premiums for months in which a Kentucky HEALTH Enrollee was fully enrolled but did not make a premium payment. Unpaid premiums during months of conditional eligibility shall not be collected by the Contractor. In pursuing the payment of Debt by an Enrollee, the Contractor shall not: (i) report the Debt to credit reporting agencies; (ii) place a lien on an Enrollee's home; (iii) refer the case to debt collectors; (iv) file a lawsuit; (v) seek a court order to seize a portion of the Enrollee's earnings; or (vi) sell the Debt for collection by a third party.

42.9 MCO Change Policies

Kentucky HEALTH Enrollees with a mandatory premium contribution and Medically Frail Enrollees may change MCOs without cause if the change is requested prior to (i) the date on which the Enrollee pays an initial premium; or (ii) the date on which the Enrollee has enrolled in Kentucky HEALTH after the sixty (60) day initial payment period has expired. Pregnant Women, Former Foster Youth, Kentucky HEALTH Children and KCHIP Enrollees may change MCOs within the first ninety (90) days of enrollment with an MCO.

All Kentucky HEALTH Enrollees may request disenrollment for cause in accordance with Section 27.13 "Enrollee Request for Disenrollment" and for any reason during the annual open enrollment period. The Department shall not approve retroactive MCO changes for cause for Kentucky HEALTH Enrollees; therefore, the Contractor shall be required to work with the Department to resolve issues related to an Enrollee's disenrollment request prior to a prospective MCO transfer. If an Enrollee is transferred from the Contractor to another MCO, the Contractor shall refund any applicable premium payment received for a future coverage month within thirty (30) days of the Enrollee's last date of participation with the Contractor.

42.10 Kentucky HEALTH Alternative Benefit Plan

Beginning July 1, 2018, ACA Expansion Enrollees shall receive all services, including coverage criteria, limitations and procedures, identified in the Kentucky HEALTH ABP. In the event that the requirements of the ABP conflict with any of the terms of this Contract, the requirements of the ABP shall prevail.

The ABP shall cover the ten (10) essential health benefits: (i) ambulatory patient services; (ii) Emergency Services; (iii) hospitalization; (iv) maternity and newborn care; (v) mental health and substance use disorder services, including behavioral health treatment; (iv) prescription drugs; (vii) rehabilitative and habilitative services and devices; (viii) laboratory services; (ix) preventive and wellness services and chronic disease management; and (x) pediatric services. The ABP shall also specify and cover additional pregnancy-only benefits which the Contractor shall only make available for ACA Expansion Enrollees who are pregnant. Additionally, the Contractor shall

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ensure that all ACA Expansion Enrollees under age twenty-one (21) are covered for EPSDT benefits in accordance with Section 33.1 "EPSDT." This shall include, but is not limited to, vision and dental coverage which are otherwise not covered under the ABP.

42.10.1 Populations Exempt from Kentucky HEALTH ABP

The following Kentucky HEALTH Enrollees shall not receive the ABP benefits described in Section 42.10 "Kentucky HEALTH ABP":

A. Parents and Caretaker Relatives;
B. TMA;
C. Former Foster Youth;
D. Pregnant Women who are not ACA Expansion Enrollees;
E. Kentucky HEALTH Children;
F. KCHIP recipients; and
G. Medically Frail Enrollees.

The Contractor shall ensure that the Enrollees described in this Section have access to Covered Services in accordance with Section 31 "Covered Services."

42.11 Non-Emergency Use of the Emergency Room

To impose copayments and My Rewards Account deductions for non-emergency use of the emergency room, as described in Sections 42.5.3 "Copayments" and 42.15 "My Rewards Account," the Contractor shall ensure that any hospital in its network providing non-emergency care in its emergency room to a Kentucky HEALTH Enrollee shall first conduct an appropriate medical screening pursuant to 42 CFR §489.24 to determine that the Enrollee does not require Emergency Services. The Contractor shall instruct its provider network of the following emergency room services copayment and My Rewards Account deduction policies and procedures, as well as the circumstances under which the hospital shall waive or return the copayment:

A. Inform Enrollees in the Copayment Plan of the amount of their cost sharing obligation for non-emergency services provided in the emergency room;
B. Inform Enrollees with a My Rewards Account that non-emergency visits shall result in a deduction to the My Rewards Account, and the deduction amount shall escalate for each inappropriate visit during the Benefit Year;
C. Provide the Enrollee with the name and location of an available and accessible alternative non-emergency services provider;
D. Determine that the alternative provider can provide services to the Enrollee in a timely manner with the imposition of a lesser cost sharing amount; and
E. Provide a referral to coordinate scheduling for treatment by the alternative provider.

42.12 Medically Frail

Enrollees who meet the definition of Medically Frail shall be enrolled in Kentucky HEALTH, but shall not be subject to: (i) Community Engagement requirements; (ii) mandatory cost sharing through premiums or copayments; or (iii) enrollment in the ABP. Medically Frail Enrollees may pay premiums in order to access a My Rewards Account. In accordance with 42 CFR §440.315(f), a person shall be determined Medically Frail if the Enrollee has a disabling mental disorder (including serious mental illness); chronic substance use disorder; serious and complex medical condition; or physical, intellectual or developmental disability which significantly impairs the Enrollee's ability to perform one or more activities of daily living.

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As described in the subsections below, Enrollees shall be identified as Medically Frail in one of the following ways: (i) State identification based on eligibility data; (ii) Enrollee self-attestation; and (iii) Contractor identification through either the Provider Attestation Scoring Tool or Medically Frail Identification Tool.

42.12.1 State Identification of Medically Frail

Individuals eligible for Kentucky HEALTH who are diagnosed with HIV/AIDs as identified by the Ryan White Program, or receiving Retirement, Survivors and Disability Insurance (RSDI) income based upon a disability, or Enrollees with refugee status following their first year of entrance into the United States, shall automatically be determined Medically Frail at the point of application. The Contractor shall not be responsible for initial confirmation or annual reconfirmation of the Medically Frail status of these Enrollees.

42.12.2 Self-Attestation of Medically Frail

Applicants and Enrollees who self-attest to chronic homelessness or inability to complete activities of daily living (ADL) and who become otherwise eligible for Kentucky HEALTH will receive six (6) months of Medically Frail status. The Contractor shall verify the Enrollee's Medically Frail status prior to the expiration of the six (6) month period. The Contractor shall provide the results of the verification to the State and to the Enrollee in accordance with Kentucky HEALTH Business Requirements and Section 42.12.3 "Contractor Medically Frail Determination."

42.12.3 Contractor Medically Frail Determination

Applicants and Enrollees can also self-report a variety of health indicators through the Cabinet operated IEES self-service portal or with the assistance of a DCBS case worker in the IEES worker portal. Upon self-attestation of a physical or behavioral health disorder, the individual will be directed to contact the Contractor to begin the Medically Frail determination process.

Enrollees may also be identified as Potentially Medically Frail through Contractor completion of the HRA, as described in Section 35.1 "Health Risk Assessment." Completion of the HRA and Enrollee self-reporting, with the exception of the self-attestation indicators specified in Section 42.12.2 "Self-Attestation of Medically Frail," does not automatically result in designation of an Enrollee as Medically Frail.

Within thirty (30) days of identification of an Enrollee as Potentially Medically Frail through the HRA, the Contractor shall determine if the Enrollee meets the Medically Frail criteria, utilizing the Medically Frail Identification Tool. If the Medically Frail Identification Tool determines the Enrollee as Possibly Medically Frail, the Contractor shall assist the Enrollee or Conditionally Eligible Enrollee in scheduling an appointment with a medical provider, who shall complete the Provider Attestation. The Contractor shall accept completed Provider Attestations, at a minimum, via fax, mail and electronically. Upon receipt of the Provider Attestation, the Contractor shall process the Provider Attestation through the Provider Attestation Scoring Tool.

The Contractor shall also identify Medically Frail Enrollees through ongoing use, on at least a monthly basis, of the Medically Frail Identification Tool. In utilizing the Medically Frail Identification Tool, the Contractor shall include all claims data, including but not limited to, denied claims, Medicare crossover claims and TPL claims. An Enrollee shall be considered Medically Frail if the Medically Frail Identification Tool identifies the Enrollee as automatically Medically Frail. If the Medically Frail Identification Tool identifies the Enrollee as Possibly

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Medically Frail, the Contractor shall assist the Enrollee in scheduling an appointment with their medical provider for completion of the Provider Attestation within sixty (60) days.

The Contractor shall notify the Department in accordance with the Kentucky HEALTH Business Requirements when an Enrollee is determined Medically Frail by the Contractor through either the Medically Frail Identification Tool or the Provider Attestation Scoring Tool. Upon receipt of the confirmation, the Department shall transfer the Enrollee to Medicaid State Plan benefits, in accordance with Section 31.1 "Medicaid Covered Services," effective the first day of the month following the Medically Frail confirmation.

Following the Medically Frail determination, the Contractor shall be responsible for notifying the Enrollee, in writing, of the decision, using a Medically Frail notice template developed by the Department. The notice shall include, at minimum, the following information:

A. The Medically Frail designation decision;
B. For denials of Medically Frail status, the reasons for the determination and the Enrollee's right to appeal;
C. A description of any changes to the Enrollee's benefits; and
D. A description of applicable changes to the Enrollee's cost sharing obligations.

Enrollees with an active My Rewards Account who were enrolled in the Premium Plan prior to a Medically Frail determination shall continue enrollment in the Premium Plan. The Contractor shall ensure, in accordance with Section 42.8.1 "Batch Invoicing," that premium invoices sent to the Enrollee following the Medically Frail determination clearly indicate that the premium obligation is optional, including consequences for non-payment. Enrollees determined Medically Frail who have a suspended My Rewards Account shall continue to have their My Rewards Account suspended, but shall no longer be responsible for copayments for services received.

42.12.4 Ongoing Review

Enrollees determined Medically Frail by the Contractor shall be deemed Medically Frail for twelve (12) months. The Contractor shall utilize the Medically Frail Identification Tool and Provider Attestation Scoring Tool to review the status of all Medically Frail Enrollees prior to the expiration of their twelve (12) month period. Enrollees who are reconfirmed Medically Frail shall receive an additional twelve (12) month Medically Frail determination.

The Contractor shall track when it identifies Enrollees whose Medically Frail status has ended prior to the end of the twelve (12) month period through the monthly run of the Medically Frail Identification Tool or via the Provider Attestation as described in Section 42.12.3 "Contractor Medically Frail Determination." If the Contractor determines that the Enrollee's Medically Frail status has ended, the Enrollee shall lose the Medically Frail designation effective the first day of the month following the determination. The Contractor shall notify the Enrollee of the denial in accordance with Section 42.12.3 "Contractor Medically Frail Determination."

Additionally, the Contractor shall review all Kentucky HEALTH Children, KCHIP Enrollees and Former Foster Youth at least thirty (30) days prior to aging out of their eligibility category and Pregnant Women prior to the end of their postpartum period to determine if they are Medically Frail.

42.12.5 Department Audit

The Department shall conduct regular audits of the Contractor's Medically Frail assessment and confirmation process pursuant to Section 42.12.3 "Contractor Medically Frail

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Determination" to determine appropriate identification and placement of Medically Frail Enrollees. The Department may subcontract this audit function.

42.13 Community Engagement Initiative

The Contractor shall:

A. Communicate Community Engagement requirements through the Enrollee handbook and other Enrollee education materials;
B. Suspend premium invoicing if an Enrollee enters a Community Engagement Suspension status, as communicated on the HIPAA 834. However, the Contractor shall continue invoicing other Enrollees in the same case who have a premium obligation;
C. Conduct outreach to Enrollees in a Community Engagement Suspension in accordance with the Department-approved outreach plan described in Section 42.8.7 "Invoicing and Outreach During Kentucky HEALTH Penalty and Suspension Period;"
D. Reinstate Batch Invoicing upon notice of an Enrollee's Community Engagement Suspension as defined in the Kentucky HEALTH Business Requirements;
E. Ensure that the Enrollee call center can address basic Enrollee inquiries regarding Community Engagement, including, but not limited to:
    1. Community Engagement requirements;
    2. Applicable exemptions and how to report meeting an exemption requirement;
    3. How to report Community Engagement hours;
    4. How to avoid Community Engagement Suspension when an Enrollee falls short in a given month;
    5. How to appeal a Community Engagement Suspension;
    6. Providing referrals to the appropriate State or vendor Community Engagement resources; and
    7. Requirements for early re-entry from a suspension status.

42.14 Deductible Account

The Contractor shall establish a Deductible Account for all Kentucky HEALTH Enrollees except for Kentucky HEALTH Children, KCHIP Enrollees, and Pregnant Women. The beginning balance of a Deductible Account shall be one thousand dollars ($1,000), regardless of a Kentucky HEALTH Enrollee's date of enrollment. The Contractor shall track the first one thousand dollars ($1,000) of non-preventive services received by Enrollees with a Deductible Account and deduct such expenses from the Deductible Account balance. The Contractor shall ensure that the amount deducted for each non-preventive service received equals the actual dollar amount that the Contractor reimbursed to the provider and is not based on the Department's fee-for-service schedule. The Contractor shall not deduct expenses for any preventive services received from the Deductible Account. For purposes of this requirement, the definition of preventive services shall be developed by the Department based on U.S. Preventive Services Task Force (USPSTF) and Centers for Disease Control (CDC) age and gender appropriate preventive services. The Contractor shall comply with the list of preventive services provided by the Department and any updates thereto.

Kentucky HEALTH Enrollees who become pregnant shall have their Deductible Account frozen during their pregnancy and through their sixty (60) day post-partum period. The Contractor shall ensure that healthcare expenses are not deducted from the Deductible Account of a female Enrollee during her pregnancy. Kentucky HEALTH applicants who are pregnant at the time of application shall not have a Deductible Account established until the close of their sixty (60) day post-partum period.

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The Contractor shall send a monthly Deductible Account statement to all Kentucky HEALTH Enrollees by the tenth day of each month, utilizing the Department's standardized template. The statement shall be sent in the preferred mode selected by the Enrollee, either via mail or electronically. The Deductible Account statement shall list, at minimum: (i) the previous statement balance; (ii) claims applied to the account during the time period in which the statement applies, including pharmacy claims; (iii) the remaining Deductible Account balance; (iv) an explanation of benefits (EOB) summary for all services received by the Enrollee during the statement period; and (v) the Contractor's helpline number for Kentucky HEALTH Enrollees to contact with questions or concerns regarding the statement.

The Contractor shall continue to send the Deductible Account Statement monthly, even after the full balance has been depleted. The Contractor shall not display a negative Deductible Account balance; rather, the balance shall be displayed as zero dollars ($0) when funds have been depleted. Exhaustion of the Deductible Account before the end of the Enrollee's Benefit Year shall not change the Contractor's covered service requirements, and the Contractor shall continue to ensure that the Enrollee is able to access covered services.

The Contractor shall implement mechanisms to ensure that its call center staff are able to view an Enrollee's Deductible Account balance and relevant transactions in order to assist with Enrollee phone calls related to the Deductible Account.

To encourage the appropriate utilization of healthcare services, Kentucky HEALTH Enrollees are eligible to have up to one-half of their remaining Deductible Account balance transferred to their My Rewards Account following the close of the Benefit Year. Enrollees with a My Rewards Account that is suspended or inactive shall not be eligible for such a transfer. The percentage of the Deductible Account balance eligible for transfer to a My Rewards Account shall be based on the number of active months of the Enrollee's enrollment in Kentucky HEALTH within a Benefit Year. For purposes of this requirement, active months are months in which an Enrollee is not disenrolled or in a suspension status. Ninety (90) days after the end of the calendar year, the Contractor shall transmit all Deductible Account balances maintained by its Kentucky HEALTH Enrollees to the Department's designee in accordance with the Kentucky HEALTH Business Requirements. The Contractor shall continue to process claims received after this transmission, but shall not be responsible for continuing to track such expenditures against Deductible Accounts.

In the event that a Kentucky HEALTH Enrollee with a Deductible Account changes MCOs during a Benefit Year, the Enrollee's Deductible Account balance information shall transfer to the Enrollee's new MCO. To facilitate this transfer, the Contractor shall transmit the Enrollee's Deductible Account balance information in accordance with the Kentucky HEALTH Business Requirements. The Contractor shall not be required to track expenditures against the Enrollee's Deductible Account from the effective date of the Enrollee's transfer to another MCO, although the Contractor shall remain responsible for claims incurred prior to the date of transfer.

42.15 My Rewards Account

All Premium Plan Enrollees shall have access to a My Rewards Account. Additionally, pregnant Enrollees aged nineteen (19) or older shall also have access to a My Rewards Account, even though they do not have a premium payment obligation. Pregnant Enrollees who are in a penalty status from their previous enrollment, however, shall not be eligible for a My Rewards Account, unless they complete a Re-Entry Course.

The My Rewards Account may be utilized by Enrollees to access the following services:

A. Routine dental benefits;

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B. Routine vision benefits;
C. Limited reimbursement for fitness activities; and
D. Other services designated by the Department.

Only ACA Expansion Enrollees receiving ABP benefits shall be required to utilize the My Rewards Account to access routine dental and vision benefits. The Contractor shall be responsible for providing routine dental and vision services for all other Kentucky HEALTH Enrollees, as described in Section 42.10.1 "Populations Exempt from Kentucky HEALTH ABP," and including ACA Expansion Enrollees who are pregnant or nineteen (19) or twenty (20) years of age. The Contractor shall ensure that if claims are submitted to the Contractor, or any applicable subcontracted entities, for dental or vision services for ACA Expansion Enrollees, the denial reason codes and explanations shall be clear that while benefits are not reimbursed by the Contractor, reimbursement may be available through the My Rewards Account.

Kentucky HEALTH Enrollees may accrue funds in their My Rewards Account by completing activities as outlined in the Kentucky HEALTH Business Requirements. The Contractor shall not be responsible for operating the My Rewards Account; however, the Contractor shall provide customer service and transmit data, in accordance with the Kentucky HEALTH Business Requirements, regarding Enrollee participation in My Rewards Account accrual activities.

The Contractor shall communicate an Enrollee's completion of any of the following preventive health activities to the Department in accordance with the Kentucky HEALTH Business Requirements:

A. Completion of a health risk assessment with the Contractor;
B. Enrollee follow-up visit to a physician within fifteen (15) days of an emergency room visit;
C. Completion of mammogram, pap smear, colonoscopy, flu shot, annual physical, preventive dental exam, preventive vision exam, or other preventive services as defined by the Department;
D. Completion of a well-child preventive or comprehensive dental exam or comprehensive vision screening for a dependent child of a Kentucky HEALTH Enrollee;
E. Participation in drug addiction counseling; and
F. Participation in smoking cessation activity.

The Department may audit the Contractor's performance regarding the submission of data upon Enrollee completion of My Rewards Account eligible activities, including, but not limited to, comparisons against submitted encounter data.

Activities eligible for My Rewards Account accrual shall be subject to change by the Department, and the Department shall provide the Contractor sixty (60) days advance notice of any such modification. The Contractor shall comply with all modifications to the activities eligible for accrual and shall begin communicating Enrollee completion of new activities for which the Contractor is responsible to the Department immediately upon the modification effective date.

Deductions shall be taken from an Enrollee's My Rewards Account for improper use of hospital emergency room services. The Contractor shall educate its provider network regarding this My Rewards Account deduction policy and ensure compliance with the requirements of Section 42.11 "Non-Emergency Use of the Emergency Room." The deduction shall be applied based on the number of improper visits as described in the table below.

Inappropriate Emergency Room Visit	**My Rewards Account Deduction**
1st visit	$20

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2nd visit	$50
3rd visit or more	$75

The Contractor shall review paid emergency room claims against the Department established list of ICD-10 diagnoses, which indicate non-emergent use of the emergency room. If the Contractor's review determines that the emergency room claim included a primary diagnosis on the non-emergent diagnosis list, the Contractor shall verify whether the Enrollee contacted the twenty-four (24) nurse hotline described in Section 23.1 "Required Functions" within twenty-four (24) hours prior to the emergency room visit. If such a call was made, the visit shall be treated as a valid emergency room visit and the Enrollee shall not be subject to a My Rewards Account deduction. If no call was made to the nurse hotline, the emergency room visit shall be considered improper, and an Enrollee with an active My Rewards Account on the date of service shall be subject to a My Rewards Account deduction. Notwithstanding this policy, if a behavioral health diagnosis is included on the emergency room claim, the visit shall be considered appropriate, and the Enrollee shall not be subject to a My Rewards Account deduction, regardless of whether the primary diagnosis on the claim is included on the non-emergent diagnosis list. The Contractor shall communicate inappropriate use of the emergency room by an Enrollee to IEES in accordance with the Kentucky HEALTH Business Requirements.

The Contractor shall comply with any updates to the non-emergent diagnoses list in accordance with any future modifications made by the Department. The Department shall provide thirty (30) days advance notice to the Contractor of any such modifications.

The Contractor shall provide Enrollee service support to Enrollees who have inquiries regarding their My Rewards Account. At a minimum, the Contractor shall provide the following information in Enrollee communication materials and via the Contractor's Enrollee helpline:

A. How Enrollees may check their My Rewards Account balance;
B. Which activities Enrollees may complete to earn funds in their My Rewards Account;
C. Which benefits can be purchased with My Rewards Account funds;
D. A link on the Contractor's website to the My Rewards Account website where Enrollees may locate all information regarding their My Rewards Account; and
E. The Enrollee's My Rewards Account balance, with the ability to transfer an Enrollee to the My Rewards Account call center identified by the Department when more complex issues such as My Rewards Account claims denials are raised.

42.16 Kentucky HEALTH Grievances and Appeals

The Contractor shall process grievances and appeals related to Kentucky HEALTH in accordance with Section 25.0 "Enrollee Grievances and Appeals" and all applicable subsections. In addition, the Contractor shall comply with the following requirements applicable to Kentucky HEALTH:

A. In the event that an Enrollee's ineligibility determination is overturned on appeal, the Contractor shall be responsible for reactivating an Enrollee's Deductible Account in accordance with the date of eligibility reinstatement. To the extent that the Enrollee's eligibility is reinstated effective in the same Benefit Year during which eligibility was initially lost, upon the reinstatement of the Enrollee's Deductible Account, the Contractor shall apply the balance that was in effect as of the date of loss of eligibility;
B. Benefits currently held by Enrollees who timely appeal a Cabinet termination of eligibility shall be continued while the appeal is pending. During the appeal period, the Contractor shall continue to send monthly premium invoices and collect premium payments in accordance with Section 42.8 "Billing and Collections;"
C. Benefits shall not be continued during an appeal period if the Enrollee's appeal concerns an

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eligibility suspension for premium non-payment;

D. If an appeal is related to an increase in premium amount, the Contractor shall invoice the Enrollee at the new premium amount, as reflected on the HIPAA 834. If the premium increase is overturned on appeal, the Contractor shall apply any overpayments made toward future months' premiums;
E. Enrollees shall continue to receive State Plan benefits in the event that they timely appeal a transition to the ABP. If a change in benefits is appealed but not within the timeframe required to continue benefits in the State Plan, the Contractor shall provide coverage to the Enrollee via the ABP. Further, in the event that the Enrollee's benefit change is overturned on appeal, the Contractor shall transfer the Enrollee to State Plan benefits in accordance with the effective date of the appeal determination;
F. The Contractor shall manage grievances related to Deductible Accounts in accordance with 42 CFR 428, Subpart F and Section 25 "Enrollee Grievances and Appeals" of this Contract. Further, the Contractor shall adjust each Deductible Account balance in alignment with the applicable grievance resolution and communicate any such balance updates in accordance with the Kentucky HEALTH Business Requirements;
G. Appeals regarding Medically Frail determinations shall be processed by the Contractor in accordance with the appeals requirements at 42 CFR 428, Subpart F and Section 25 "Enrollee Grievances and Appeals" of this Contract. In the event that an Enrollee subsequently appeals the Contractor's appeal decision to the Cabinet, the Contractor shall comply with requests for documentation from the Department, its designee, or State Fair Hearings. The Contractor shall comply with the final determination of the Enrollee's Medically Frail status, including the application of benefits and cost sharing in accordance with Kentucky HEALTH policy; and
H. Appeals of eligibility suspension due to premium non-payment shall be processed by State Fair Hearings; however, the Contractor shall provide to the Cabinet either proof of payment receipt, or non-payment.

42.17 Recertification

Kentucky HEALTH Enrollees shall complete an eligibility recertification every twelve (12) months, in accordance with 42 CFR §435.916. If eligibility is maintained at recertification, the Kentucky HEALTH Enrollee shall maintain enrollment in their current cost sharing plan (i.e., Premium Plan or Copayment Plan).

ACA Expansion Enrollees, Parent and Caretaker Relatives, and TMA Enrollees who are not Medically Frail and who fail to submit required recertification documentation within ninety (90) days of their benefit end date shall be subject to a six (6) month recertification penalty, during which they shall be prohibited from re-enrolling in Kentucky HEALTH. Kentucky HEALTH Enrollees shall be exempted from the six (6) month recertification penalty period if they meet a just cause exemption, as defined by the Department. Additionally, Kentucky HEALTH Enrollees may complete a Re-Entry Course to initiate early re-entry into Kentucky HEALTH prior to the expiration of the six (6) month recertification penalty period.

To facilitate the continuous enrollment of Kentucky HEALTH Enrollees, and to minimize the number of Enrollees subject to the recertification penalty, the Contractor is encouraged to assist Enrollees in the recertification process. Permitted assistance may include:

A. Conducting outreach calls and sending letters to Enrollees reminding them to renew their eligibility. All recertification call center scripts and letters shall be subject to Department approval in accordance with Section 4.4 "Approval of Department;"
B. Reviewing recertification requirements with Enrollees;
C. Answering questions about the recertification process; and
D. Helping the Enrollee to obtain required documentation and collateral verification needed to process the recertification.

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In providing recertification assistance, the Contractor shall be prohibited from the following:

A. Discriminating against Enrollees, particularly high-cost Enrollees or Enrollees that have indicated a desire to change MCOs;
B. Talking to Enrollees about changing MCOs. If an Enrollee has questions or requests to change MCOs, the Contractor shall refer the Enrollee to the Department;
C. Providing any indication as to whether the Enrollee may be eligible;
D. Engaging in or supporting fraudulent activity in association with helping the Enrollee complete the recertification process;
E. Signing the Enrollee's recertification forms; and
F. Completing or sending recertification materials to DCBS on behalf of the Enrollee.

The Contractor shall provide recertification assistance equally across its membership and be able to demonstrate to the Department that its recertification-related procedures are applied consistently for each Enrollee.

42.18 Kentucky HEALTH Contract Compliance Requirements

The Contractor shall comply with the Kentucky HEALTH performance standards described in this Section. Failure to meet these standards shall subject the Contractor to the penalties described herein, and as applicable, the remedies in Section 40 "Remedies for Violation, Breach, or Non-Performance of Contract."

42.18.1 Premium Collection

The Contractor shall provide premium collection services in accordance with the standards described below.

A. Premium invoices shall be sent to Conditionally Eligible Enrollees within three (3) business days of receipt of the HIPAA 834 indicating conditional eligibility.
B. Ongoing premium invoices shall be sent to Kentucky HEALTH Enrollees enrolled in the Premium Plan by the fifteenth day of the month for the subsequent month's coverage.
C. Contractor invoice information shall be sent to IEES for each Kentucky HEALTH Enrollee and Conditionally Eligible Enrollee with a premium obligation in accordance with the Kentucky HEALTH Business Requirements.
D. Record of premium payment receipt or non-payment for Kentucky HEALTH Enrollees shall be sent to IEES in accordance with Kentucky HEALTH Business Requirements no later than the sixth of each month.
E. Record of premium payment or non-payment for Conditionally Eligible Enrollees shall be sent to IEES in accordance with Kentucky HEALTH Business Requirements no later than seventy-five (75) days after the Conditionally Eligible Enrollee's eligibility determination.

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APPENDICES

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APPENDIX A. CAPITATION PAYMENT RATES

Kentucky Department for Medicaid Services
Cabinet for Health and Family Services **Confidential and Proprietary**
Base Capitation, Supplemental Payment, and HIF Rates **Exhibit 1b**
Effective July 1, 2019 - June 30, 2020
Including July 1, 2019 Program Change Amendment

	Base Capitation Rates		Supplemental Payment PMPM		HIF PMPM	
	Region A	Region B	Region A	Region B	Region A	Region B
Families & Children						
Infant - Age Under 1	$927.17	$836.90	$209.09	$76.76	$28.41	$22.84
Child - Age 1 to 5	$154.15	$152.51	$11.50	$7.57	$4.14	$4.00
Child - Age 6 to 12	$189.19	$179.32	$7.36	$4.87	$4.91	$4.60
Child - Age 13 to 18 Female	$280.92	$274.91	$16.48	$8.78	$7.44	$7.09
Child - Age 13 to 18 Male	$226.70	$203.41	$10.80	$6.86	$5.94	$5.26
Adult - Age 19 to 24 Female	$564.83	$543.13	$56.38	$17.94	$15.53	$14.03
Adult - Age 19 to 24 Male	$184.50	$249.14	$17.60	$11.70	$5.05	$6.52
Adult - Age 25 to 39 Female	$574.13	$579.01	$47.10	$17.13	$15.53	$14.90
Adult - Age 25 to 39 Male	$317.87	$374.57	$19.77	$10.00	$8.44	$9.61
Adult - Age 40 or Older Female	$657.14	$713.24	$32.93	$18.59	$17.25	$18.30
Adult - Age 40 or Older Male	$650.97	$597.49	$45.77	$17.40	$17.42	$15.37
SSI Adults without Medicare						
Age 19 to 24 Female	$781.61	$947.73	$69.73	$61.37	$21.28	$25.23
Age 19 to 24 Male	$544.21	$553.01	$34.65	$26.80	$14.47	$14.50
Age 25 to 44 Female	$1,346.87	$1,255.25	$132.78	$52.09	$36.99	$32.68
Age 25 to 44 Male	$1,138.07	$995.74	$110.42	$40.18	$31.21	$25.90
Age 45 or Older Female	$1,841.54	$1,680.67	$145.89	$49.22	$49.69	$43.25
Age 45 or Older Male	$1,800.49	$1,509.73	$162.27	$62.49	$49.07	$39.31
Dual Eligible						
Female	$206.97	$223.29	$11.97	$6.25	$5.47	$5.74
Male	$199.86	$208.09	$15.79	$5.90	$5.39	$5.35
SSI Child						
Age Under 1	$9,080.31	$8,699.58	$1,531.54	$1,375.66	$265.30	$251.88
Age 1 to 5	$1,343.13	$1,286.81	$226.54	$203.48	$39.24	$37.26
Age 6 to 18	$852.77	$754.55	$42.74	$24.14	$22.39	$19.47
Foster Care						
Infant - Age Under 1	$1,245.39	$985.16	$130.42	$73.08	$34.40	$26.46
Age 1 to 5	$307.09	$242.92	$32.16	$18.02	$8.48	$6.52
Age 6 to 12	$547.45	$350.84	$9.33	$6.55	$13.92	$8.93
Age 13 or Older Female	$802.11	$572.22	$19.57	$13.98	$20.54	$14.66
Age 13 or Older Male	$604.09	$444.71	$21.22	$8.32	$15.63	$11.33
Former Foster Care Child						
Age 18 through 20 Female	$563.05	$529.68	$56.68	$16.59	$15.49	$13.66
Age 18 through 20 Male	$411.47	$293.70	$88.20	$20.04	$12.49	$7.84
Age 21 through 25 Female	$563.05	$529.68	$56.68	$16.59	$15.49	$13.66
Age 21 through 25 Male	$411.47	$293.70	$88.20	$20.04	$12.49	$7.84
MAGI Adult						
Age through 18 Female	$324.65	$327.16	$22.94	$11.39	$8.69	$8.46
Age through 18 Male	$229.95	$203.00	$34.05	$8.31	$6.60	$5.28
Age 19 through 24 Female	$324.65	$327.16	$22.94	$11.39	$8.69	$8.46
Age 19 through 24 Male	$229.95	$203.00	$34.05	$8.31	$6.60	$5.28
Age 25 through 39 Female	$483.25	$479.79	$31.55	$16.22	$12.87	$12.40
Age 25 through 39 Male	$425.44	$406.91	$47.44	$16.21	$11.82	$10.58
Age 40 or Older Female	$783.15	$805.39	$51.32	$25.72	$20.86	$20.78
Age 40 or Older Male	$756.86	$738.81	$69.41	$30.88	$20.66	$19.24

Notes

Rates are consolidated to the following two regions:

Rating Region A: Region 3

Rating Region B: Regions 1,2,4,5,6,7, and 8

MMIS system will still load eight regions

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APPENDIX B. MEDICAL LOSS RATIO CALCULATION

Unless specifically addressed below, the Medical Loss Ratio (MLR) calculation shall follow guidelines described in the Affordable Care Act. The formula to be used for the MLR Calculation is as follows:

Adjusted MLR = [(i + q – s + n - r)/{(p + s - n + r) - t – f - (s -n + r)}] + c

Where,

i = incurred claims
q = expenditures on quality improving activities
s = issuer's transitional reinsurance receipts
p = earned premiums (excluding MCO tax)
t = Federal and State taxes (excluding MCO tax)
f = licensing and regulatory fees
n = issuer's risk corridors and risk adjustment related payments
r = issuer's risk corridors, and risk adjustment related receipts
c = credibility adjustment, if any.

Additional guidance regarding financial items to excluded or included in the Numerator or Denominator of the Medical Loss Ratio calculation is as follows:

- **Numerator**

•Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services, or services meeting the definition in §438.3(e) and provided to an enrollee.

•<u>Incurred Claims</u>

•Direct claims that the MCO pays to providers (including under capitation contracts with health care professionals) for services or supplies covered under the managed care contract with DMS, provided to enrollees;
•Direct claims that the MCO pays to providers (including under capitation contracts with health care professionals) for services or supplies defined under §438.3(e) that are in addition to services defined in the managed care contract with DMS, provided to enrollees
•Incurred but not reported and unpaid claims reserves for the MLR Reporting year, including claims reported in the process of adjustment;
•Percentage withholds from payments made to contracted providers;
•Claims that are recoverable for anticipated coordination of benefits;
•Claims payments recoveries received as a result of subrogation;
•Changes in other claims-related reserves;
•Claims payments recoveries as a result of fraud reductions efforts, not to exceed the amount of fraud reduction expenses;
•Reserves for contingent benefits and the medical claim portion of lawsuits; and
•The amount of incentive and bonus payments made to providers.

•<u>Deductions from Claims</u>

•Overpayment recoveries received from providers;
•Prescription drug rebates received by the MCO or PIHP; and

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- •State subsidies based on a stop-loss payment methodology.

•Solvency Funds

- •Payments made by an MCO to mandated solvency funds.

•Health Care Quality Activities May be included in numerator

- •Any MCO expenditure that is related to Health Information Technology and meaningful use, and is not considered incurred claims.

•Excluded from Claims

- •Amounts paid to third party vendors for secondary network savings;
- •Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management; and
- •Amounts paid to the State as remittance
- •Pass-through Payments made under 42 CFR 438.6(d)

➢ **Denominator**

•Revenue

- •State capitation payments to the MCO for all enrollees under a risk contract less any unreturned withholds
- •State-developed one time payments, for specific life events;
- •Payments to the MCO for incentive arrangements or payments for the amount of a withhold the MCO earns in accordance with conditions in the contract
- •Unpaid cost sharing amounts that the MCO could have collected from enrollees under the contract
- •All changes to unearned premium reserves.

•Exclusions

- •Federal and State taxes and licensing and regulatory fees. Taxes, licensing and regulatory fees
  - •e.g. Health Insurer Fee
- •Statutory assessments to defray the operating expenses of any State or Federal department.
- •State taxes and assessments
- •Pass-through Payments made under 42 CFR 438.6(d)

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APPENDIX C. THIRD PARTY PAYMENTS/COORDINATION OF BENEFITS

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

A.

Maintaining an MIS that includes:

1. Third Party Liability Resource File

   a) Cost Avoidance - Use automated daily and monthly TPL files to update the MCO's MIS TPL files as appropriate. This information is to cost avoid claims for members who have other insurance.

      The MCO shall obtain subscriber data and perform data matches directly with a specified list of insurance companies, as defined by DMS.

   b) 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.

   c) Workers' Compensation - The fiscal agent performs this function. The data is provided electronically on a quarterly basis. This data should be applied to TPL files referenced in I.A.1.a (Commercial Data Matching) in this Attachment.

2. Third Party Liability Billing File

   a) Commercial Insurance/Medicare Part B Billing - The MCO'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 MCO's MIS that was unknown to the MCO 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 MCO'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 MCO's MIS that was unknown to the MCO at the time of payment of a claim. Providers who do not dispute the

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Medicare coverage should be instructed to bill Medicare immediately. The MCO'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 coverages 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 MCO 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

   Provide the necessary information regarding paid claims in order to seek recovery from liable parties in legal actions involving Members.

   In cases where an attorney has been retained, a lawsuit filed or a lump sum settlement offer is made, the MCO shall notify Medicaid within five days of identifying such information so that recovery efforts can be coordinated when the Department has a claim for the same accident.

C.

Claims

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1. Processing

   a)

   MCO 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 MCO'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 MCO 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 MCO's MIS Third Party Files.

2. Encounter Record

   a)

   TPL Indicator

   b)

   TPL Payment

II. DMS shall be responsible for the following:

1. Provide the MCO with an initial third party information tape;

2. Provide electronic computerized files of third party information transmitted from DCBS;

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3. Provide the MCO with a copy of the information received from the Labor Cabinet on a quarterly basis;
4. Provide the MCO with a list of the Division of Child Support Contracting Officials.
5. Refer calls from attorneys to the MCO in order for their Claims to be included in casualty settlements; and
6. Monitoring Encounter Claims and reports submitted by the MCO to ensure that the MCO performs all required activities.

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APPENDIX D. MANAGEMENT INFORMATION SYSTEM REQUIREMENTS

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.

Member Subsystem

The primary purpose of the member subsystem is to accept and maintain an accurate, current, and historical source of demographic information on Members to be enrolled by the Contractor.

The maintenance of enrollment/member data is required to support Claims and encounter processing, third party liability (TPL) processing and reporting functions. The major source of enrollment/member data will be electronically transmitted by the Department to the Contractor on a daily basis in a HIPAA 834 file format. The daily transaction file will include new, changed and terminated member information. The Contractor shall be required to process and utilize the daily transaction files prior to the start of the next business day. A monthly HIPAA 834 file of members will be electronically transmitted to the Contractor. The Contractor must reconcile Member and Capitation Payment information with the Department for Medicaid Services.

Specific data item requirements for the Contractor's Member subsystem shall contain such items as maintenance of demographic data, matching Primary Care Providers with Members, maintenance information on Enrollments/Disenrollments, identification of TPL information, tracking EPSDT preventive services and referrals.

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)

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- 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 if applicable.
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 K.

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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.

Third Party Liability (TPL) Subsystem

In order to ensure that federal third party liability requirements are met and to maximize savings from available Third Party Resources, identification and recovery of Third Party Resources must be a joint effort between the Department and the Contractor. The Department will provide Contractor with the Medicare effective dates.

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

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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

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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;

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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.

Provider Subsystem

The provider subsystem 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 shall electronically transmit provider enrollment information to the Department on a monthly basis, by the first Friday of the month following the month reported.

The Contractor's provider subsystem shall contain such items as demographic data, identification of provider type, specialty codes, maintenance of payment information, identification of licensing, credentialing/re-credentialing information, and monitoring of Primary Care Provider capacity for enrollment purposes.

The Contractor shall demonstrate compliance with standards of provider network capacity and member access to services by producing reports illustrating that services, service locations, and service sites are available and accessible in terms of timeliness, amount, duration and personnel sufficient to provide all Covered Services on an emergency or urgent care basis, 24 hours a day, seven days a week.

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The Department shall monitor the Contractor's Network capacity and member access by use of a Decision Support System. The Encounter Record submitted will be used to display Primary Care Provider location, Service Location, Member distribution, patterns of referral, quality measures, and other analytical data.

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 National Provider Identification (NPI);
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, certification(s), specialty,

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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

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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 Appendix J.

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.

Reference Subsystem

The reference subsystem maintains pricing files for procedures and drugs, and maintains other general reference information such as diagnoses, edit/audit criteria, edit dispositions and reimbursement parameters/modifiers. The reference subsystem provides a consolidated source of reference information which is accessed by the MIS during the performance of other functions, including Claims and encounter processing, TPL processing and utilization/quality reporting functions.

The Contractor's reference subsystem shall contain such items as maintenance of procedure codes/NDC codes and diagnosis codes, identification of pricing files, maintenance of edit and audit criteria.

The contractor must maintain sufficient reference data (NDC codes, HCPCS,

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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

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- 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.

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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.

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.

The Contractor's financial subsystem shall contain such items as: update of provider payment data, tracking of financial transactions, including TPL recoveries and maintenance of adjustment and recoupment processes.

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.

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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.

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

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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.

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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 J and Contractor Reporting Requirements Section of Contract.

Utilization/Quality Improvement

The Contractor shall capture and maintain a patient-level record of each service provided to Members using CMS 1500, UBO4, NCPDP, HIPAA code sets or other Claim or Claim formats that shall meet the reporting requirements in this Contract. The computerized database must contain and hold a complete and accurate representation of all services covered by the Contractor, and by all providers and Subcontractors rendering services for the contract period. The Contractor shall be responsible for monitoring the integrity of the database and facilitating its appropriate use for such required reports as encounter data, and targeted performance improvement studies.

Contractor shall comply with the requirements of 42 CFR 455.20 (a) by employing a selected sample method approved by CMS and the Department of verifying with Members whether the services billed by provider were received.

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The utilization/quality improvement subsystem combines data from other subsystems, and/or external systems, to produce reports for analysis which focus on the review and assessment of access, availability and continuity of services, quality of care given, detection of over and underutilization of services, 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.

The subsystem shall support tracking utilization control function(s) and monitoring activities, including Geo Network for all Encounters in all settings particularly in-patient and outpatient care, emergency room use, outpatient drug therapy, EPSDT and out-of-area services. It shall complete provider profiles; occurrence reporting, including adverse incidents and complications, monitoring and evaluation studies; Members and Providers aggregate Grievances and Appeals; effects of educational programs; 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.

The Contractor's utilization/quality improvement subsystem shall contain such items as: monitoring of primary care and specialty provider referral patterns processes to monitor and identify deviations in patterns of treatment from established standards or norms, performance and health outcome measures using standardized indicators. The quality improvement subsystem will be based upon nationally recognized standards and guidelines, including but not limited to, a measurement system based upon the most current version of HEDIS published by the National Committee for Quality Assurance.

Surveillance Utilization Review Subsystem (SURS)

In accordance with 42 CFR 455, the Contractor shall establish a SURS function which provides the capability to identify potential fraud and/or abuse of providers or Members. The SURS component supports profiling, random sampling, groupers (for example Episode Treatment Grouper), ad hoc and targeted queries.

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 underutilization, 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

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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.

Claims Control and Entry

The Claims Control function ensures that all claims are captured at the earliest

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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).

Edit/Audit Processing

The Claims processing subsystem collects, processes, and stores data on all health services delivered. The functions of this subsystem are Claims payment processing and capturing medical service utilization data. Claims are screened against the provider and Member subsystems. The Claims processing subsystem captures all medically related services, including medical supplies, using standard codes (e.g. HCPCS, ICD9-CM/ICD-10 CM/PCS diagnosis and procedure code, Revenue Codes, ADA Dental Codes and NDCs) rendered by medical providers to a Member regardless of remuneration arrangement (e.g. capitation/fee-for-service). The Contractor shall be required to electronically transmit Encounter Record to the Department on a weekly basis, or on a department approved schedule that is determined by the Contractor's financial schedule.

The Contractor's Claims processing/encounter subsystem shall contain such items as: apply edit and audit criteria to verify timely, accurate and complete Encounter Record; edit for prior-authorized Claims; identify error codes for Claims.

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; pended 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.

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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 criterion 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.).

Claims Pricing

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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 the 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.

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

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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 fifteen 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

Analysis and Reporting Function

The analysis capacity function supports reporting requirements for the Contractor and the Department with regard to the QAPI program and managed care operations. The Contractor shall show sufficient capacity to support special requests and studies that may be part of the financial and quality systems. The reporting subsystem allows the Contractor to develop various reports to enable

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Contractor management and the Department to make informed decisions regarding managed care activity, costs and quality.

The Contractor's reporting subsystem shall contain such items as: specifications for a decision support system; capacity to collect, analyze and report performance data sets such as may be required under this Contract; HEDIS performance measures; report on Provider rates, federally required services, reports such as family planning services, abortions, sterilizations and EPSDT services.

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APPENDIX E. BUSINESS ASSOCIATES AGREEMENT

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement"), effective _____("Effective Date") is entered into by and between_____ , located at _____("Business Associate") and the Cabinet for Health and Family Services, the Department for Medicaid Services, ("Covered Entity"), individually referred to herein as a "Party" and collectively as "Parties".

The Business Associate herein is a _____ and the Covered Entity herein is the designated agency to administer the Kentucky Medicaid Program. The parties have an agreement for the provision of _____ ("Contract") under which the Business Associate herein may use or disclose Protected Health Information in the performance of the services described in the contract. The parties herein entered into a Master Contract on the ___ day of _____, _____, under which the Business Associate may use and/or disclose Protected Health Information (PHI) in performance of the services described in the Contract. Both parties are committed to complying with the Standards for Privacy and Security of Individually Health Information ("Privacy and Security Regulations") promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Agreement sets forth the terms and conditions pursuant to which Protected Health Information that is provided by the Covered Entity to the Business Associate, or created, received, maintained or transmitted by the Business Associate on behalf of the Covered Entity, will be handled between the Business Associate and the Covered Entity and with third parties during the term of the Contract and after termination.

WHEREAS, Sections 261 through 264 of the Federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, directs the Secretary of the Department of Health & Human Services to develop standards to protect the security, confidentiality and integrity of health information; and

WHEREAS, the Secretary of HHS has duly promulgated such administrative regulations found at 45 C.F.R. § 160 and § 164, known as the HIPAA Privacy Rule; and

WHEREAS, the Parties are desirous to enter into or have entered into an agreement whereby the Business Associate will provide certain services to the covered entity herein, and pursuant to such agreement, the Business Associate may be considered a "business associate" of the Covered Entity as defined in the HIPAA Privacy Rule; and

WHEREAS, the Business Associate under the contract will have access to Protected Health Information in fulfilling its responsibilities under such agreement; and

WHEREAS, Business Associate agrees to collect and destroy any and all recyclable

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material produced by the Covered Entity, and is to assume responsibility for these documents upon receipt.

NOW THEREFORE THE PARTIES TO THIS AGREEMENT, for just and valuable consideration which both parties acknowledge herein, the Parties agree to the provisions of this Agreement in order to address the requirements of the HIPAA Privacy and Security Rules and to protect the interest of both parties.

1. **PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

1.1 Services. Pursuant to this Contract, Business Associate provides services ("Services") for the Covered Entity that involve the use and/or disclosure of protected health information (PHI). Except as otherwise specified herein, the business associate may make any and all uses of PHI necessary to perform its obligations under the contract, provided that such use would not violate the Privacy and Security Regulations if done by the Covered Entity or the minimum necessary policies and procedures of the Covered Entity. Moreover, the Business Associate may disclose PHI for the purposes authorized by this Agreement only, (i) to its employees, subcontractors and agents, in accordance with Section 2.1 (e), (ii) as directed by the Covered Entity, or (iii) as otherwise permitted by the terms of this Agreement including, but not limited to, Section 1.2 (b) below, provided that such disclosure would not violate the Privacy and Security Regulations if done by the Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

1.2 Business Activities of the Business Associate. Unless otherwise limited herein the Business Associate may:

a. Use the Protected Health Information in its possession for its proper management and administration and to fulfill any present or future legal responsibilities of the Business Associate provided that such are permitted under State and Federal laws.
b. Disclose the Protected Health Information in its possession to third parties for the purpose of its proper management and administration or to fulfill any present or future legal responsibilities of the Business Associate, provided that the Business Associate represents to the Covered Entity, in writing, that (i) the disclosures are required by law, as that phrase is defined in 45 C.F.R. § 164.501 or (ii) the Business Associate has received from the third party written assurances regarding the confidential handling of such Protected Health Information as required by 45 C.F.R. § 164.504 (e) (4), and the third party agrees in writing to notify Business Associate of any instances of which it becomes aware that the confidentiality of the information has been breached.

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2. RESPONSIBILITIES OF THE PARTIES WITH RESPECT TO PROTECTED HEALTH INFORMATION

2.1 Responsibilities of the Business Associate. With respect to its use and/or disclosure of Protected Health Information, the Business Associate hereby agrees to do the following:

a. Shall use and disclose the Protected Health Information only in the amount minimally necessary to perform the services of the Contract or under this Agreement, provided that such use or disclosure would not violate the Privacy and Security Regulations if done by the Covered Entity or as required by law.
b. Shall immediately report to the designated privacy officer of the covered entity, in writing, any use and/or disclosure of unsecured Protected Health Information that is not permitted or required by this Agreement or required by law.
c. Establish procedures for mitigating, to the greatest extent possible, any deleterious effects from any improper use and/or disclosure of PHI that the Business Associate reports to the Covered Entity.
d. Use appropriate administrative, technical and physical safeguards to maintain the privacy and security of PHI and to prevent uses and/or disclosures of unsecured PHI other than as provided in this Agreement.
e. Require all of its subcontractors and agents that receive or use, or have access to, PHI provided under this Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and/or disclosures of PHI that apply to the Business Associate pursuant to this Agreement.
f. Make available all policies, records, books, agreements, records or procedures relating to the use or disclosure of Protected Health Information to the Secretary of Health & Human Services for purposes of determining the Business Associates' compliance with the Privacy and Security Regulations.
g. Upon written request, make available during normal working hours at Business Associate's office all records, books, agreements, policies and procedures relating to the use and disclosure of Protected Health Information to the Covered Entity to determine the Business Associate's compliance with the terms of this Agreement.
h. Upon Covered Entity's request, Business Associate shall provide to the Covered Entity an accounting of each disclosure of PHI made by the Business Associate or its employees, agents, representatives, or subcontractors. Business Associate shall implement a process that allows for an accounting to be collected and maintained for any disclosure of PHI for which Covered Entity is required to maintain. Business Associate shall include in the accounting: (a) date of the disclosure; (b) the name, and address if known, of the entity or person who received the PHI; (c) a brief description of the PHI disclosed; and (d) a brief statement of the purpose of the disclosure. For each disclosure that requires an

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accounting under this section, Business Associate shall document the information specified in (a) through (d), and shall securely retain the documentation for six (6) years from the date of the disclosure. To the extent that the Business Associate maintains PHI in an electronic format, Business Associate shall maintain an accounting of disclosures for treatment, payment, and other health care operations purposes for three (3) years from the disclosure. Notwithstanding anything to the contrary, this agreement shall become effective upon either of the following: (a) on or after January 1, 2014, if the Business Associate acquired the electronic record before January 1, 2009; or (b) on or after January 1, 2011 if Business Associate acquired an electronic health record after January 1, 2009, or such later date as determined by the Secretary.

i. Subject to Section 4.5 below, Business Associate shall return to the covered entity or destroy, at the termination of this Agreement, the PHI in its possession and retain no copies which shall include for the purposes of this Agreement without limitations the destruction of all backup tapes.
j. Disclose to its subcontractors, agents, or other third parties, and request from the covered entity, only the minimum PHI necessary to perform or fulfill a specific function required by this Agreement or the Contract or permitted by law.
k. Business Associate agrees to immediately report to the covered entity any security incident involving the attempted or successful unauthorized access, use, disclosure, modification, or destruction of covered entity's electronic PHI or interference with the systems operations in an information system that involves the covered entity's electronic PHI. An attempt unauthorized access, for purposes of reporting to the covered entity, means any attempted unauthorized access that prompts Business Associate to investigate the attempt, or review or change its current security measures. The parties acknowledge that the foregoing does not require Business Associate to report attempted unauthorized access that results in Business Associate: (i) investigating solely for the purposed of reviewing and or noting the attempt, but rather requires notification only when such attempted unauthorized access results in Business Associate conducting a material and full-scale investigation ("Material Attempt"); and (ii) continuously reviewing, updating and modifying its security measures to guard against unauthorized access to its system, but rather requires notification only when a Material Attempt results in significant modifications to the Business Associate's security measures in order to prevent such Material Attempt in the future.
l. Business Associate agrees to use appropriate administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information (EPHI) that

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it creates, receives, maintains or submits on behalf of the covered entity as required by 45 C.F.R. §164.308, §164.310, §164.312, and § 164.314.

m. Business Associate agrees that any EPHI it acquires, maintains, receives or transmits will be maintained or transmitted in a manner that fits the definition of secure PHI as that term is defined by the American Recovery and Reinvestment Act of 2009 ("ARRA") and any subsequent regulations or guidelines from the Secretary of the Department of Health and Human Services ("DHHS") promulgated under ARRA.

n. Business Associate agrees to ensure that any agency, including subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate safeguards to protect it as required by 45 C.F.R. §164.308, §164.310, §164.312 and §164.414.

o. The Business Associate agrees to immediately notify the covered entity of any breach of unsecured PHI . Notice of such breach shall include the identification of each individual whose unsecured PHI has been, or reasonably believed by the business associate to have been, accessed, acquired or disclosed during the breach. Notice shall also include the description of the PHI involved in the breach, description of the factual grounds leading to the breach, and any remedial action taken to address the breach. Business Associate further agrees to make available in a reasonable time and manner any other information needed by covered entity to respond to the individual's inquiries regarding said breach and to report the breach to the Secretary of the Department of Health and Human Services. Business Associate shall be responsible to notify in writing the individuals affected by the breach as required under HIPAA regulations, but shall have the notice approved before mailing by the covered entity.

p. Business Associate agrees to indemnify the covered entity for the reasonable costs to notify the individuals affected by the breach if the covered entity provides that notice, and for any costs, damages, fines, penalties, including attorney fees, incurred by covered entity as a result of the breach by the Business Associate or its employees, agents or subcontractors, including but not limited to any identity theft related prevention or monitoring costs.

q. Business Associate shall make available PHI in a designated record set to the covered entity or to the individual requesting access to PHI as necessary to satisfy covered entity's obligations under 45 C.F.R. §164.524. If the information is maintained in an electronic format, the access shall be provided to the individual in the electronic format.

r. Business Associate shall make any amendments to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 C.F.R. §164.526 or take other measures as necessary to satisfy covered entity's obligations under 45 C.F.R. §164.526.

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s. Business Associate, to the extent the business associate is to carry out one or more of the covered entity's obligations under Subpart E of 45 C.F.R. part 164 shall comply with the requirements found therein which apply to the covered entity's performance of such obligations.
t. Business Associate agrees to comply with any and all privacy and security provisions not otherwise specified herein made applicable to the Business Associate under the provisions of HIPAA or ARRA.

2.2 Responsibilities of the Covered Entity. With regard to the use and/or disclosure of Protected Health Information by the Business Associate, the covered entity hereby agrees:

a. Covered entity shall inform the Business Associate of any changes in the form of notice of privacy practices ("Notice") that the covered entity provides to individuals pursuant to 45 C.F.R. § 164.520, and provide, upon request, the Business Associate a copy of the Notice currently in use.
b. Covered entity shall inform the Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate's use and disclosure of protected health information pursuant to 45 C.F.R. § 164.508.
c. Covered entity shall notify business associate of any limitations or restrictions placed upon PHI to the extent such restrictions or limitations affect the business associate's use or disclosure of protected health information.
d. Covered entity shall notify business associate of any amendments made to PHI at the request of any individual for the Business Associate to correct the PHI in accordance with the amendment.
e. Covered entity shall notify the Business Associate of any opt-outs exercised by any individual from fundraising activities of the covered entity pursuant to 45 C.F.R. § 164.514(f).
f. Covered entity shall notify Business Associate, in writing and in a timely manner, of any arrangements permitted or required of the covered entity under 45 C.F.R. Part 160 or 164 that may impact in any manner the use and/or disclosure, including but not limited to, restrictions on use and/or disclosure of PHI as provided for in 45 C.F.R. § 164.522 agreed to by the covered entity.

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APPENDIX F. ENCOUNTER DATA SUBMISSION REQUIREMENTS AND QUALITY STANDARDS

I. Contractor's Encounter Data

A. Submissions

The Contractor is required to electronically submit Encounter data to the Department on a weekly scheduled basis. The submission is to include all adjudicated (paid and denied) Claims, corrected claims and adjusted claims processed by the Contractor. Contractor shall submit all claims within thirty days of adjudication. Encounter File transmissions that exceed a 5% threshold error rate (total claims/documents in error equal to or exceed 5% of claims/documents records submitted) will be subject to penalties as provided in the Contract. Encounter File transmissions with a threshold error rate not exceeding 5% will be accepted and processed by the Department. Only those Erred Encounters will be returned to the contractor for correction and resubmission. Denied claims submitted for encounter processing will not be held to normal edit requirements and rejections of denied claims will not count towards the minimum 5% rejection.

Encounter data must be submitted in the format defined by the Department as follows:

1. Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010 transaction 837 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version 2.2. Example transactions include the following:
   - 837I – Instructional Transactions
   - 837P – Professional Transactions
   - 837D – Dental Transactions
   - 278 – Prior Authorization Transactions
   - 835 – Remittance Advice
   - 834 – Enrollment/Disenrollment
   - 820 – Capitation
   - 276/277 Claims Status Transactions
   - 270/271 Eligibility Transactions
   - 999 – Functional Acknowledgement
   - NCPDP 2.2

2. Conversion from ICD-9 to ICD-10 for medical diagnosis and inpatient procedure coding by October 1, 2015.

   The Contractor is required to use procedure codes, diagnosis codes and other codes used for reporting Encounter data in accordance with guidelines defined by the Department. The

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Contractor must also use appropriate provider numbers as directed by the Department for Encounter data. The Encounters will be received and processed by Fiscal Agent and will be stored in the existing MIS.

B. Encounter Corrections

Encounter corrections (encounter returned to the Contractor for correction, i.e., incorrect procedure code, blank value for diagnosis codes) will be transmitted to the Contractor electronically for correction and resubmission. Penalties will be assessed against the Contractor for each Encounter record, which is not resubmitted within thirty (30) days of the date the record is returned.

C. Annual Validity Study

The Department will conduct an annual validity study to determine the completeness, accuracy and timeliness of the Encounter data provided by the Contractor.

Completeness will be determined by assessing whether the Encounter data transmitted includes each service that was provided. Accuracy will be determined by evaluating whether or not the values in each field of the Encounter accurately represent the service that was provided. Timeliness will be determined by assuring that the Encounter was transmitted to the Department the month after adjudication. The Department will randomly select an adequate sample which will include hospital claims, provider claims, drug claims and other claims (any claims except in-patient hospital, provider and drug), to be designated as the Encounter Processing Assessment Sample (EPAS). The Contractor will be responsible to provide to the Department the following information as it relates to each Claim in order to substantiate that the Contractor and the Department processed the claim correctly:

- A copy of the claim, either paper or a generated hard copy for electronic claims;
- Data from the paid claim's file;
- Member eligibility/enrollment data;
- Provider eligibility data;
- Reference data (i.e., diagnosis code, procedure rates, etc.) pertaining to the Claim;
- Edit and audit procedures for the Claim;
- A copy of the remittance advice statement/explanation of benefits;
- A copy of the Encounter Record transmitted to the Department; and
- A listing of Covered Services.

The Department will review each Claim from the EPAS to determine if complete, accurate and timely Encounter data was provided to the

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Department. Results of the review will be provided to the Contractor. The Contractor will be required to provide a corrective action plan to the Department within sixty (60) Days if deficiencies are found.

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APPENDIX G. HEDIS MEASURES INCENTIVE PROGRAM (REMOVED)

This appendix was removed in a previous contract modification.

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APPENDIX H. COVERED SERVICES

I. Contractor Covered Services

A. Alternative Birthing Center Services
B. Ambulatory Surgical Center Services
C. Behavioral Health Services – Mental Health and Substance Abuse Disorders
D. Chiropractic Services
E. Community Mental Health Center Services
F. Dental Services, including Oral Surgery, Orthodontics and Prosthodontics
G. Durable Medical Equipment, including Prosthetic and Orthotic Devices, and Disposable Medical Supplies
H. Early and Periodic Screening, Diagnosis & Treatment (EPSDT) screening and special services
I. End Stage Renal Dialysis Services
J. Family Planning Services in accordance with federal and state law and judicial opinion
K. Hearing Services, including Hearing Aids for Members Under age 21
L. Home Health Services
M. Hospice Services (non-institutional only)
N. Independent Laboratory Services
O. Inpatient Hospital Services
P. Inpatient Mental Health Services
Q. Meals and Lodging for Appropriate Escort of Members
R. Medical Detoxification, meaning management of symptoms during the acute withdrawal phrase from a substance to which the individual has been addicted.
S. Medical Services, including but not limited to, those provided by Physicians, Advanced Practice Registered Nurses, Physicians Assistants and FQHCs, Primary Care Centers and Rural Health Clinics
T. Organ Transplant Services not Considered Investigational by FDA
U. Other Laboratory and X-ray Services
V. Outpatient Hospital Services
W. Outpatient Mental Health Services
X. Pharmacy and Limited Over-the-Counter Drugs including Mental/Behavioral Health Drugs
Y. Podiatry Services
Z. Preventive Health Services, including those currently provided in Public Health Departments, FQHCs/Primary Care Centers, and Rural Health Clinics
AA. Psychiatric Residential Treatment Facilities (Level I and Level II)
BB. Specialized Case Management Services for Members with Complex Chronic Illnesses (Includes adult and child targeted case management)
CC. Specialized Children's Services Clinics
DD. Targeted Case Management

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EE. Therapeutic Evaluation and Treatment, including Physical Therapy, Speech Therapy, Occupational Therapy
FF. Transportation to Covered Services, including Emergency and Ambulance Stretcher Services
GG. Urgent and Emergency Care Services
HH. Vision Care, including Vision Examinations, Services of Opticians, Optometrists and Ophthalmologists, including eyeglasses for Members Under age 21

II. Member Covered Services and Summary of Benefits Plan

A. General Requirements and Limitations

The Contractor shall provide, or arrange for the provision of, health services, including Emergency Medical Services, to the extent services are covered for Members under the then current Kentucky State Medicaid Plan, as designated by the department in administrative regulations adopted in accordance with KRS Chapter 13A and as required by federal and state regulations, guidelines, transmittals, and procedures.

This Appendix was developed to provide, for illustration purposes only, the Contractor with a summary of currently covered Kentucky Medicaid services and to communicate guidelines for the submission of specified Medicaid reports. The summary is not meant to act, nor serve as a substitute for the then current administrative regulations and the more detailed information relating to services which is contained in administrative regulations governing provision of Medicaid services (907 KAR Chapters 1, 3 4, 8, 9, 10, 11, 13, 15 and 17) and in individual Medicaid program services benefits summaries incorporated by reference in the administrative regulations. If the Contractor questions whether a service is a Covered Service or Non-Covered Service, the Department reserves the right to make the final determination, based on the then current administrative regulations in effect at the time of the contract.

Administrative regulations and incorporated by reference Medicaid program services benefits summaries may be accessed by contacting:

Kentucky Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Kentucky's Medicaid State Plan, administrative regulations, and incorporated by reference materials are also accessible via the Internet at http://www.chfs.ky.gov/dms/Regs.htm.

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Kentucky Medicaid covers only Medically Necessary services. These services are considered by the Department to be those which are reasonable and necessary to establish a diagnosis and provide preventive, palliative, curative or restorative treatment for physical or mental conditions in accordance with the standards of health care generally accepted at the time services are provided, including but not limited to services for children in accordance with 42 USC 1396d(r). Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The amount, duration, or scope of coverage must not be arbitrarily denied or reduced solely because of the diagnosis, scope of illness, or condition.

The Contractor shall provide any Covered Services ordered to be provided to a Member by a Court, to the extent not in conflict with federal laws. The Department shall provide written notification to the Contractor of any court-ordered service. The Contractor shall additionally cover forensic pediatric and adult sexual abuse examinations performed by health care professional(s) credentialed to perform such examinations and any physical and sexual abuse examination(s) for any Member when the Department for Community Based Services is conducting an investigation and determines that the examination(s) is necessary.

III. EMERGENCY CARE SERVICES (42 CFR 431.52)

The Contractor must provide, or arrange for the provision of, all covered emergency care immediately using health care providers most suitable for the type of injury or illness in accordance with Medicaid policies and procedures, even when services are provided outside the Contractor's region or are not available using Contractor enrolled providers. Conditions related to provision of emergency care are shown in 42 CFR 438.144.

IV. MEDICAID SERVICES COVERED AND NOT COVERED BY THE CONTRACTOR

The Contractor must provide Covered Services under current administrative regulations. The scope of services may be expanded with approval of the Department and as necessary to comply with federal mandates and state laws. Certain Medicaid services are currently excluded from the Contractor benefits package, but continue to be covered through the traditional fee-for-service Medicaid Program. The Contractor will be expected to be familiar with these Contractor excluded services, designated Medicaid "wrap-around" services and to coordinate with the Department's providers in the delivery of these services to Members.

Information relating to these excluded services' programs may be accessed by the Contractor from the Department to aid in the coordination of the services.

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A. Health Services Not Covered Under Kentucky Medicaid

Under federal law, Medicaid does not receive federal matching funds for certain services. Some of these excluded services are optional services that the Department may or may not elect to cover. The Contractor is not required to cover services that Kentucky Medicaid has elected not to cover for Members.

Following are services currently not covered by the Kentucky Medicaid Program:

- Any laboratory service performed by a provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA). This requirement applies to all facilities and individual providers of any laboratory service;
- Cosmetic procedures or services performed solely to improve appearance;
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only;
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, invitro fertilization, etc.);
- Induced abortion and miscarriage performed out-of-compliance with federal and Kentucky laws and judicial opinions;
- Paternity testing;
- Personal service or comfort items;
- Post mortem services;
- Services, including but not limited to drugs, that are investigational, mainly for research purposes or experimental in nature;
- Sex transformation services;
- Sterilization of a mentally incompetent or institutionalized member;
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services;
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein; and
- Services for which the Member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage.;

V. Health Services Limited by Prior Authorization

The following services are currently limited by Prior Authorization of the Department for Members. Other than the Prior Authorization of organ transplants, the Contractor may establish its own policies and procedures relating to Prior Authorization.

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Special

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Services

The Contractor is responsible for providing and coordinating Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), and EPSDT Special Services, through the primary care provider (PCP), for any Member under the age of twenty-one (21) years.

EPSDT Special Services must be covered by the Contractor and include any Medically Necessary health care, diagnostic, preventive, rehabilitative or therapeutic service that is Medically Necessary for a Member under the age of twenty-one (21) years to correct or ameliorate defects, physical and mental illness, or other conditions whether the needed service is covered by the Kentucky Medicaid State Plan in accordance with Section 1905 (a) of the Social Security Act.

- Transplantation of Organs and Tissue (Must be in compliance with State Plan and 907 KAR 1:350.)

- Other Prior Authorized Medicaid Services

Other Medicaid services limited by Prior Authorization are identified in the individual program coverage areas in Section VI.

VI. Current Medicaid Programs' Services and Extent of Coverage

The Contractor shall cover all services for its Members at the appropriate level, in the appropriate setting and as necessary to meet Members' needs to the extent services are currently covered. The Contractor may expand coverage to include other services not routinely covered by Kentucky Medicaid, if the expansion is approved by the Department, if the services are deemed cost effective and Medically Necessary, and as long as the costs of the additional services do not affect the Capitation Rate.

The Contractor shall provide covered services as required by statutes or administrative regulations. The current location of Covered Services can be found in the following regulations:

- Alternative Birthing Center Services (907 KAR 1:180)
- Ambulatory Surgical Center (907 KAR 1:008)
- Behavioral Health Service Organization Services (907 KAR 15:020)
- Behavioral Health Services Provided by Independent Providers (907 KAR 15:010)
- Chemical Dependency Treatment Center Services (907 KAR 15:080)
- Chiropractic Services (907 KAR 3:125)
- Commission for Children with Special Health Care Needs (911 KAR Chapter 1)

  Coverage includes physician, EPSDT, dental, occupational therapy,

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physical therapy, speech therapy, durable medical equipment, genetic screening and counseling, audiological, vision, case management, laboratory and x-ray, psychological and hemophilia treatment and related services.

- Community Mental Health Center Primary Care Services (907 KAR 1:046)
- Community Mental Health Center Behavioral Health Services (907 KAR 1:044)
- Dental Health Services (907 KAR 1:026)
- Dialysis Center Services (907 KAR 1:400)
- Durable Medical Equipment, Medical Supplies, Orthotic and Prosthetic Devices (907 KAR 1:479)
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (907 KAR 11:034)
- Family Planning Clinic Services (907 KAR 1:048 & 1:434)
- Federally Qualified Health Clinics, Primary Care Clinics and Rural Health Center Services (907 KAR 1:054, 1:082,)
- Hearing Program Services (907 KAR 1:038)
- Home Health Services (907 KAR 1:030)
- Hospice Services – non-institutional (907 KAR 1:330 & 1: 436)
- Hospital Inpatient Services (907 KAR 10:012)
- Hospital Outpatient Services (907 KAR 10:014)
- Independent Occupational Therapy Services (907 KAR 8:005 and 907 KAR 8:101)
- Independent Physical Therapy Services (907 KAR 8:005 and 907 KAR 8:020)
- Independent Speech Language Pathology Services (907 KAR 8:005 and 907 KAR 8:030)
- Inpatient Psychiatric Hospital Services (907 KAR 10:016)
- Laboratory Services (907 KAR 1:028)
- Medical Necessity and Clinical Appropriate Determination Basis (907 KAR 3:130)
- Medicare Non-Covered Services (907 KAR 1:006)
- Mental Health Inpatient Services (907 KAR 10:012 & 10:016)
- Mental Health Outpatient Services (see physician, community mental health center, FQHC and RHC, 907 KAR Chapter 15)
- Psychiatric Hospital Inpatient Services (907 KAR 10:016)
- Psychiatric Hospital Outpatient Services (907 KAR 10:020)
- Nursing Facility Services (907 KAR 1:022 & 1:037)
- Organ Transplants (907 KAR 1:350)
- Other Laboratory and X-ray Provider Services (907 KAR 1:028)
- Outpatient Pharmacy Prescriptions and Over-the-Counter Drugs including Behavioral Health Drugs (907 KAR 1:019, KRS 205.5631, 205,5632, 205.560)
- Outpatient Psychiatric Hospital Behavioral Health Services (907 KAR 10:020)

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- Physicians and Nurses in Advanced Practice Medical Services (907 KAR 3:005 and 907 KAR 1:102)
- Podiatry Services (907 KAR 1:270)
- Preventive and Remedial Public Health Services (907 KAR 1:360)
- Private Duty Nursing (907 KAR Chapter13)
- Psychiatric Residential Treatment Facility Services – (907 KAR 9:005)
- Residential Crisis Stabilization Unit Services (907 KAR 15:075)
- Specialized Children's Services Clinics (907 KAR 3:160)
- Sterilization, Hysterectomy and Induced Termination of Pregnancy Procedures (Sterilizations of both male and female Members are covered only when performed in compliance with 42 CFR 441.250, KRS 205.560 and *Glenda Hope, et al. v. Masten Childers, et al.*
- Substance Use Disorder Services (907 KAR 15:005, 907 KAR 15:010 – 15:025
- Targeted Case Management Services (907 KAR15:005, 907 KAR 15:040 - 15:065)
- Tobacco Cessation Services (907 KAR 3:215)
- Transportation, including Emergency and Non-emergency Ambulance (907 KAR 1:060)
- Vaccines for Children (VFC) Program (907 KAR 1:680)
- Vision Services (907 KAR 1:632)

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APPENDIX I. TRANSITION/COORDINATION OF CARE PLANS

Upon receipt of a HIPAA 834 indicating that a Member is transferring from one Medicaid Managed Care Organization (Former MCO) to another MCO (New MCO), the Former MCO shall be responsible to contact the New MCO, the recipient and the recipient's providers in order to transition existing care. A Prior Authorization (PA) shall be honored by the New MCO for 90 days or until the recipient or provider is contacted by the New MCO regarding the PA. If the recipient and provider are not contacted by the New MCO, the existing Medicaid PA shall be honored until expired.

Hospital Admission Prior to the Member's Transition.
If the Member is an in-patient in any facility at the time of transition, the entity responsible for the Member's care at the time of admission shall continue to provide coverage for the Member at that facility, including all Professional Services, until the recipient is discharged from the facility for the current admission. An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a "current admission." The "same diagnosis" is defined as the first five digits of a diagnosis code.

Outpatient Facility Services and Non-Facility Services
Effective on the Member's Transition date, the New MCO will be responsible for outpatient services both facility and non-facility. Outpatient reimbursement includes outpatient hospital, ambulatory surgery centers, and renal dialysis centers.

Nursing Homes
Eligibility for Long Term Care in a Nursing Facility (NF) includes some financial requirements not needed for basic Medicaid eligibility. When an eligible member enters an NF the facility must receive a Level of Care (LOC) determination to ensure the member meets medical criteria for Nursing Facility. That LOC is passed electronically to the DCBS eligibility worker, triggering the eligibility determination for this additional benefit. That determination can generally be completed within thirty days. *Once LTC eligible, worker entries exempt the member from managed care effective with the next feasible month.* If the worker action is completed prior to cut off (eight business days before the end of the month), managed care ends at the last day of current month. If the action is after cut off, managed care ends the last day of the following month. During this transition, the MCO will be responsible for ancillary, physician and pharmaceuticals charges and the Department will reimburse for those services billed by Nursing Facility. Once exempt from Managed Care, the Department will be responsible for all eligible services associated with this recipient.

Waiver Participation
1915(c) Home and Community Based Services Wavier programs are simply added benefits for eligible members; however, the action that exempts those members from being subject to Managed Care resides with the DCBS eligibility

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worker. These services require a Level of Care (LOC). The LOC is passed electronically to the DCBS eligibility worker; receipt of the LCO triggers the eligibility worker to complete entries within the eligibility system. Those entries exempt the member from managed care effective the next feasible month. If the worker action is completed prior to cut off (eight business days before the end of the month), managed care ends at the last day of current month. If the action is after cut off, managed care ends the last day of the following month. During this transition, the MCO will be responsible for all services except the additional Waiver benefits. The Waiver Services will be paid by the Department as fee for service. Coding in our billing system allows the Wavier Service to be processed during the transition period, once the eligibility worker has completed the necessary entries. Once exempt from Managed Care the Department will be responsible for all services associated with this recipient.

Transplants

Follow up care provided on or after the Member's Transition that is billed outside the Global Charges, will be the responsibility of the New MCO.

Eligibility Issues

For a Member who loses eligibility during an inpatient stay, an MCO is responsible for the care through discharge if the hospital is compensated under a DRG methodology or through the day of ineligibility if the hospital is compensated under a per diem methodology.

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APPENDIX J. CREDENTIALING PROCESS

Provider Enrollment Coversheet

1. Provider Name
2. Address-Physical & telephone number
3. Address-Pay-to-address
4. Address-Correspondence
5. E-mail address
6. Address-1099 & telephone number
7. Fax Number
8. Electronic Billing
9. Specialty
10. SSN/FEIN#
11. License#/Certificate
12. Begin and End date of Eligibility
13. CLIA
14. NPI
15. Taxonomy
16. Ownership (5%or more)
17. Previous Provider Number (if applicable) this also includes Change in Ownership
18. Existing provider number if EPSDT
19. Tax Structure
20. Provider Type
21. DOB
22. Supervising Physician (for Physician Assist)
23. Map 347 (need group# and effective date)
24. EFT (Account # and ABA #)
25. Bed Data
26. DEA (Effective and Expiration dates)
27. Fiscal Year End Date
28. Document Control Number
29. Contractor Credentialing Date
30. Credentialing Required

Credentialing and Recredentialing Requirements

This documentation shall include, but not be limited to, defining the scope of providers covered, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements. The Contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers. Those providers accountable to a formal governing body for review of credentials shall include physicians, dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant and other licensed or certified practitioners. Providers required to be recredentialed by the Contractor per

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Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department. The Contractor shall be responsible for the ongoing review of provider performance and credentialing as specified below:

A. The Contractor shall verify that its enrolled network Providers to whom Members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations and have in effect such current policies of malpractice insurance as may be required by the Contractor.
B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the Department.
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.
D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 205.560(12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.

The process for verification of Provider credentials and insurance shall include the following:

A. Written policies and procedures that include the Contractor's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;
C. A review of the credentialing policies and procedures by the formal body;
D. A credentialing committee which makes recommendations regarding credentialing;
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;
F. Written procedures for the termination or suspension of Providers; and
G. Written procedures for, and implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.

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The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of Provider's credentials shall include the following:

A. A current valid license or certificate to practice in the Commonwealth of Kentucky;
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;
C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program as applicable; if provider is not board certified.
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;
E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;
F. Previous five (5) years' work history;
G. Professional liability claims history;
H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;
I. Current, adequate malpractice insurance, as verified through attestation;
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;
K. Documentation of curtailment or suspension of medical staff privileges;
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;
M. Documentation of censure by the State or County professional association; and
N. Most recent information available from the National Practitioner Data Bank.
O. Health and Human Services Office of Inspector General (HHS OIG)
P. System for Award Management (SAM)

The provider shall complete a credentialing application that includes a statement by the applicant regarding:

A. The ability to perform the essential functions of the positions, with or without accommodation;
B. Lack of present illegal drug use;
C. History of loss of license and felony convictions;
D. History of loss or limitation of privileges or disciplinary activity;
E. Sanctions, suspensions or terminations imposed by Medicare or

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Medicaid; and

F. Applicants attest to the correctness and completeness of the application.

Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:

A. National practitioner data bank, if applicable;
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.

At the time of credentialing, the Contractor shall perform an initial visit to providers as it deems necessary and as required by law. (See 42 CFR Part 455 Subpart E.). The Contractor shall document a structured review to evaluate the site against the Contractors organizational standards and those specified by this contract. The Contractor shall document an evaluation of the medical record documentation and keeping practices at each site for conformity with the Contractors organizational standards and this contract.

The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:

A. A current license to practice;
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;
C. A valid DEA number, if applicable;
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and
F. A current signed attestation statement by the applicant regarding:
    (1) The ability to perform the essential functions of the position, with or without accommodation;
    (2) The lack of current illegal drug use;
    (3) A history of loss, limitation of privileges or any disciplinary action; and
    (4) Current malpractice insurance.
    (5) Health and Human Services Office of Inspector General (HHS OIG)
    (6) System for Award Management (SAM)

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There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:

A. The national practitioner data bank;
B. Medicare and Medicaid;
C. State boards of practice, as applicable; and
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.

The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers, and clinics. At least every three (3) years, the Contractor shall confirm that the provider is in good standing with state and federal regulatory bodies, including the Department, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.

The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services. The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.

If a provider requires review by the Contractor's credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.

The contractor shall use the provider type summaries listed at http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm

APPENDIX K. REPORTING REQUIREMENTS AND REPORTING DELIVERABLES

Document Name	MCO Reports Description
Date Created	September 4, 2011
Last Revised	**June 11, 2019**
Owner	Medicaid Managed Care Oversight Contract Management

Report#	Report Name	Status
1	NAIC Annual Financial Statement	Active
2	Audit/Internal Control	Active
3	NAIC Quarterly Financial Statement	Active
4	Executive Summary	Active
5	Enrollment Changes by Quarter	Inactive
6	Member Requested Change in PCP Assignment	Inactive
6	Member Requested Change in PCP Assignment (Annual)	Inactive
7	PCP Requested Change in Member Assignment	Inactive
7	PCP Requested Change in Member Assignment (Annual)	Inactive
8	MCO Initiated Change in PCP Assignment	Inactive
8	MCO Initiated Change in PCP Assignment (Annual)	Inactive
9	PCPs with Panel Changes Greater than 50 or 10%	Inactive
9	PCPs with Panel Changes Greater than 50 or 10% (Annual)	Inactive
10	Narrative for MCO Report #s 6-8	Inactive
11	Call Center	Active
11B	KY HEALTH Call Center	Active
12	Provider Network File Layout	Inactive
12A	Geo Access Network Reports and Maps	Active
13	Access and Delivery Network Narrative	Active
14	Denial of MCO Participation (Quarterly)	Inactive
15	Subcontractor Monitoring	Inactive
16	Summary of Quality Improvement Actives; Monitoring Indicators, Benchmarks and Outcomes	Active
17	Quality Assessment and Performance Improvement Work Plan; Utilization of Subpopulations and Individuals with Special Healthcare Needs	Active
18	Monitoring Indicators, Benchmarks and Outcomes;	Inactive
19	Performance Improvement Projects	Inactive
20	Utilization of Subpopulations and Individuals with Special Healthcare Needs	Inactive
21	MCO Committee Activity	Active
22	Satisfaction Survey(s)	Active
23	Evidence Based Guidelines for Practitioners	Inactive
24	Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death	Inactive
25	Overview of Activities	Inactive
26	Credentialing and Re-credentialing Activities During the Quarter	Inactive
27	Grievance Activity	Active
27B	KY HEALTH Grievance Activity	Active
28	Appeal Activity	Active
28B	KY HEALTH Appeal Activity	Active
29	Grievances and Appeals Narrative	Active
30	Quarterly Budget Issues	Inactive
31	Potential or Anticipated Fiscal Problems	Inactive
32	Enrollment Summary	Inactive
33	Utilization of Ambulatory Care by Age Breakdown	Inactive
34	Utilization of Emergency and Ambulatory Care Resulting in Hospital Admission	Inactive
35	Emergency Care by ICD-9 Diagnosis	Inactive
36	Home Health Utilization	Inactive
37	Utilization of Ambulatory Care by Provider Type and Category of Aid	Inactive
38	Behavioral Health Services In/Out State Facility Utilization	Active
39	Monthly Formulary Management	Active
40A	Top 50 Psych Drugs by Quantity Reimbursed	Inactive
40B	Top 50 Psych Drugs by Reimbursement	Inactive
41	Top 50 OTC Drugs by Reimbursement	Inactive
42A	Top 50 Prescribers by Reimbursement	Inactive
42B	Top 50 Prescribers of Controlled Drugs by Reimbursement	Inactive
42C	Top 50 BH Prescribers by Reimbursement	Inactive
43	Top 50 Controlled Drugs by Quantity Reimbursed	Inactive
44	Top 50 Drugs by MCO Reimbursement	Inactive
45a	Top 50 Drugs by Quantity	Inactive
45B	Top 50 Non PDL Drugs by Reimbursement	Inactive
46	Systems Development and Encounter Data	Inactive
47	Claims Processing Timeliness/Encounter Data Processing	Inactive
48	Organizational Changes	Inactive
49	Administrative Changes	Inactive
50A, 50B	Post Payment Billing Recovery	Active
51	Operational Changes	Active
52	Expenditures Related to MCO's Operations	Active
53	Prompt Payment	Active
54	COB Savings	Active
55	Medicare Cost Avoidance	Active

56	non-Medicare Cost Avoidance	Active
57	Potential Subrogation	Active
58	Original Claims Processed	Active
58B	KY HEALTH Original Claims Processed	Active
59	Prior Authorizations	Active
60	Original Claims Inventory	Active
61	Denied Claims Activity	Inactive
62	Suspended Claims Activity	Inactive
63	Claims Inventory	Inactive
64	Monthly Benefit Payments	Active
65	Foster Care	Active
66	Guardianship	Active
67	Provider Credentialing Activity	Inactive
68	Additions to Provider Network	Active
69	Termination from MCO Activity	Active
70	Denial of MCO Participation	Active
71	Provider Outstanding Accounts Receivables	Active
72	Member Violation Letters and Collections	Active
73	Explanation of Member Benefits (EOMB)	Active
74A	Medicaid Program Lock-In Reports/Admits Savings Summary Table	Active

74B	Medicaid Program Lock-In Reports/Rolling Annual Calendar Comparison	Active
74C	Medicaid Program Lock-In Reports/Member Initial Lock-In Effective Dates	Active
75	SUR Algorithms	Active
76	Provider Fraud Waste and Abuse	Active
77	Member Fraud Waste and Abuse	Active
78	Quarterly Benefits Payment	Active
79	Health Risk Assessments	Active
80	Provider Changes in Network	Inactive
81	Par and Non-Par Provider Participation	Inactive
82	Status of all Subcontractors	Inactive
83	Disease and Case Management Activity	Inactive
84	Quality Assessment and Performance Improvement Project Description	Active
85	Quality Improvement Plan and Evaluation	Active
86	Annual Outreach Plan	Active
87	DMS Copied on Report to Management of any Changes in Member Services Function to Improve the Quality of Care Provided or Method of Delivery	Inactive
88	Absent Parent Canceled Court Order Information	Inactive
89	List of Members Participating with the Quality Member Access Advisory Committee	Inactive
90	Performance Improvement Projects Proposal	Active
91	Abortion Procedures	Active
92	Performance Improvement Projects Measurement	Active
93	EPSDT CMS – 416	Active
94	Member Surveys	Active
95	Provider Surveys	Active
96	Audited HEDIS Reports	Active
97	Behavioral Health Adults and Children Population	Active
98	Behavioral Health Pregnant and Postpartum	Inactive
99	Behavioral Health Intravenous Drug Users	Inactive
100	EPSDT for Behavioral Health Populations	Inactive
101	Access to Behavioral Healthcare Providers	Inactive
101A	Behavioral Health and Wellness	Inactive
102	Behavioral Health and Chronic Physical Health	Inactive
103	Behavioral Health Facilities Report	Inactive
104	Behavioral Health Expenses PMPQ	Inactive
105A	Behavioral Health Service Utilization – Primary BH	Inactive
105B	Behavioral Health Service Utilization – Primary SUD	Inactive
105C	Behavioral Health Service Utilization – primary BH paid claims only	Inactive
105D	Behavioral Health Service Utilization – primary SUD paid claims only	Inactive
106	Behavioral Health Pharmacy for all MCO Members – Adults and Children	Inactive
107A	Behavioral Health Service Prior Authorization – BH	Inactive
107B	Behavioral Health Service Prior Authorization – SUD	Inactive
108	Unduplicated Number of Adults and Children/Youth Received PRTF – Level I and Level II	Inactive
109	Unduplicated Number and Percentage of Adults and Children/Youth Readmitted to PRTF	Inactive
110A	Original Behavioral Health Claims Processed (By license Type)	Inactive
110B	Original Behavioral Health Claims Processed (by service type for non-licensed providers)	Inactive

111	Unduplicated Number and Percentage of Adults with SMI	Inactive
112	Unduplicated Number and Percentage of Adults with SMI and Children/Youth with SED Received with Co-occurring Mental Health Abuse Disorders	Inactive
113	Unduplicated Number and Percentage of Children/Youth with SED Therapy or Family Functional Therapy	Inactive
114	Unduplicated Number and Percentage of Children/Youth with SED who were assessed for Trauma History	Inactive
115	Unduplicated Number of Adults and Children/Youth of their Caregivers Received Peer Support Service	Inactive
116	Unduplicated Number and Percentage of Pregnant and Post-partum women with Substance use Disorders Received First Treatment within 48 hours	Inactive
117	Unduplicated Number and Percentage of Children/Youth Discharged from PRTF	Inactive
118	Behavioral Health Outcomes	Inactive
119	Mental Health Statistics Improvement Project Adult Survey	Active
120	Youth Services Satisfaction Caregiver Survey	Active
121	Unduplicated Number of Adults and Children/Youth with Behavioral Health Diagnosis' with PCP	Inactive
122	Unduplicated Number of Children/Youth with Behavioral Health Diagnoses Received Annual Wellness Check/Health Exam	Inactive
123	Unduplicated Number of Adults and Children/Youth General Behavioral Health Diagnosis and Chronic Physical Health Diagnosis	Inactive
124	Unduplicated Number of Adults and Children/Youth with Regular use of Tobacco Products	Inactive
125	Unduplicated Number of Adults and Children/Youth Screened for Substance Use Disorder in Physical Care Setting	Inactive
126	Federally Qualified Health Centers	Active
127	Statement on Standards for Attestation Engagements (SSAE) No. 16	Active
173	MCO-PBM Compliance Report for POS Transactions	Active
200	834 RECONCILATION REPORTS	Active
205	Assignment Inquiry	Inactive
210	Duplicate Member	Inactive
220	Newborn	Active
230	Capitation Payment Request	Active
240	Capitation Duplicate Payment	Inactive
250	Capitation Adjustment Requests	Active
251	Provider Credentialing Status Report	Active
252	IMD Report Institution for Mental Diseases 15 Days	Active
253	IMD Report Institution for Mental Diseases-Residential Treatment for Substance Use Disorder (SUD) 30 Days	Active
260	MCO Claims Paid for Voided Members	Inactive
300	Quarterly LRC Report	Active

Exhibit #	**Exhibit Name**		
Exhibit A	Billing Provider Type and Specialty Crosswalk		
Exhibit B	Billing Provider Type Category Crosswalk		
Exhibit C	Provider Enrollment Activity Reasons		
Exhibit D	Category of Service Crosswalk		
Exhibit E	EPSDT Category of Service Crosswalk		
Exhibit F	Medicaid Eligibility Group		
Exhibit G	Behavioral Health Population Definitions	Revised	12/15/15
Exhibit H	MH/SA Procedure Codes	Inactive	07/29/13
Exhibit I	Mental Health Evidence Based Practices Definitions	Revised	07/29/13
Exhibit J	BHDID Psychotropic Medication Class Codes	Revised	07/29/13
Exhibit K	Behavioral Health and Chronic Physical Health	Revised	07/29/13

Note: A report will not be required to be submitted to the Department during the period the report has a status of 'Inactive'.

Report #:	1	Created:	09/10/2011
Name:	NAIC Annual Financial Statement	Last Revised:	09/24/2011
Group:	Finance and Medicaid Managed Care Oversight	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	January 1 through December 31		
Due Date:	Date Submitted to DOI		
Submit To:	Kentucky Department of Insurance Kentucky Department for Medicaid Services		

Description:

NAIC Financial Statement and Supplements are required by the Kentucky Department of Insurance (DOI). MCOs are required to comply with the DOI filing requirements. A copy of the NAIC Financial Statement and Supplements are required to be submitted to the Department for Medicaid Services (DMS) at the same time the reports are submitted to the DOI. Any revisions of the documents submitted to the DOI are also to be submitted to the DMS at the same time. Due date for the Annual Financial Statement and Supplements is March 1 as stated in the DOI NAIC Checklist for Health.

Report #:	2	Created:	09/10/2011
Name:	Audit/Internal Control	Last Revised:	09/24/2011
Group:	Finance and Medicaid Managed Care Oversight	Report Status:	Active
Frequency:	Annual or as Appropriate	Exhibits:	NA
Period:	As Required by DOI		
Due Date:	Date Submitted to DOI		
Submit To:	Kentucky Department of Insurance Kentucky Department for Medicaid Services		

Description:

MCOs are required to comply with the Kentucky Department of Insurance (DOI) requirements for Audit/Internal Control reporting as referenced in the DOI NAIC Checklist for Health. A copy of the Audit/Internal Control reports are required to be submitted to the Department for Medicaid Services (DMS) at the same time the reports are submitted to the DOI. Any revisions of the documents submitted to the DOI are also to be submitted to the DMS at the same time.

Report #:	3	Created:	09/10/2011
Name:	NAIC Quarterly Financial Statement	Last Revised:	09/24/2011
Group:	Finance and Medicaid Managed Care Oversight	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of the quarter through the last day of the quarter.		
Due Date:	Date Submitted to DOI		
Submit To:	Kentucky Department of Insurance Kentucky Department for Medicaid Services		

Description:

NAIC Quarterly Financial Statement and Supplements are required by the Kentucky Department of Insurance (DOI). MCOs are required to comply with the DOI filing requirements. A copy of the NAIC Quarterly Financial Statement and Supplements are required to be submitted to the Department for Medicaid Services (DMS) at the same time the reports are submitted to the DOI. Any revisions of the documents submitted to the DOI are also to be submitted to the DMS at the same time. Due dates for the Quarterly Financial Statement and Supplements are May 15, August 15 and November 15 as stated in the DOI NAIC Checklist for Health.

Report #:	4	Created:	12/12/2011
Name:	Executive Summary	Last Revised:	
Group:	Executive Summary	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provide a narrative overview summarizing 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 MCO plans to address in the future, and a summary of all press releases and issues covered by the press.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 4: Executive Summary

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

I. **Significant Operational Activities**
   A. Overview of Success Stories and Positive Results
   B. Problems or Issues Identified
   C. Other Plan Activities

II. **Summary of Reports**
   A. Eligibility and Enrollment;
   B. Access/Delivery Network
   C. Quality Assurance/Performance Improvement(QAPI)
   D. Grievance/Appeals
   E. Budget Neutrality
   F. Utilization
   G. Systems
   H. Other Plan Activities

III. **Summary of Media/Press Releases**

Media Source	Name	Date	Title-Subject	Highlight-Overview

Report #:	11	Created:	08/27/2011
Name:	Call Center	Last Revised:	09/01/2011
Group:	Member Services and Quality	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
	First day of month through the last day of the month.		
Due Date:	By the 15h of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provides MCO reporting of call center performance in the areas of abandonment, blockage rate and average speed of answer. A total for all Splits/VDN and each individual Split/VDN is to be reported.

Sample Layout:

Member (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>

	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Behavioral Health (Main/Trunk)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Provider (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Medical Advice (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

<List Other by Name> (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
<List Other by Name>	The report is to include all Main/Trunk lines that the MCO or the MCO subcontractors maintain. Additional sections of the report are to be added as needed.

Row Label	Description
Number of Calls	Number of calls received including answered, abandoned and blocked.
Number of Calls Abandoned	Calls into the call centers that are terminated by the persons originating the call before answer by a staff person. (URAC standards measure this as the calls that disconnect after 30 seconds when a live individual would have answered the call. If there is a pre-recorded message or greeting for the caller, the 30-second measurement begins after the message/greeting has ended).
% Abandoned Calls	The percentage of calls into the call center that are terminated by the persons originating the call before answer by a staff person. (URAC standards measure this as the percentage of calls that disconnect after 30 seconds when a live individual would have answered the call. If there is a pre-recorded message or greeting for the caller, the 30-second measurement begins after the message/greeting has ended)

Average Speed to Answer (seconds)	The average delay in seconds that inbound telephone calls encounter waiting in the telephone queue of a call center before answer by a staff person (URAC measures the speed of answer starting at the point when a live individual would have answered the call. If there is a pre-recorded message or greeting for the caller, the time it takes to respond to the call – average speed of answer – begins after the message/greeting has ended).
Highest Maximum Delay (minutes)	The one call during the reporting period that had the greatest delay in speed to answer measured in minutes.
% Calls Answered on or before 4th Ring	The percentage of calls answered on or before the fourth ring.
% Calls Receiving Busy Signal	The percentage of incoming telephone calls 'blocked' or not completed because switching or transmission capacity is unavailable, as compared to the total number of calls encountered. Blocked calls usually occur during peak call volume periods and result in callers receiving a busy signal.
% Calls Answered within 30 Seconds	The percentage of calls answered within thirty seconds.
Average Length of Call (minutes)	The average length of all calls answered measured in minutes.

Column Label	**Description**
Total All Incoming Calls/VDN	Report a total for all incoming calls to the Main/Trunk line.
<name of split>	A separate column needs to be added to the report for each individual Split/VDN maintained for the Main/Trunk line.
mm/yyyy	The reporting period represented by a two character number for the month (mm) and a four character number for the year (yyyy). Example: January 2012 would be represented as 01/2012.

Report #:	11B KY HEALTH	Created:	07/11/2018
Name:	Call Center	Last Revised:	
Group:	Member Services and Quality	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
	First day of month through the last day of the month.		
Due Date:	By the 15h of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

KY HEALTH Report provides MCO reporting of call center performance in the areas of abandonment, blockage rate and average speed of answer. A total for all Splits/VDN and each individual Split/VDN is to be reported.

Sample Layout:

Member (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Behavioral Health (Main/Trunk)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Provider (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Medical Advice (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

<List Other by Name> (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

<List Other by Name>	The report is to include all Main/Trunk lines that the MCO or the MCO subcontractors maintain. Additional sections of the report are to be added as needed.

Row Label	Description
Number of Calls	Number of calls received including answered, abandoned and blocked.
Number of Calls Abandoned	Calls into the call centers that are terminated by the persons originating the call before answer by a staff person. (URAC standards measure this as the calls that disconnect after 30 seconds when a live individual would have answered the call. If there is a pre-recorded message or greeting for the caller, the 30-second measurement begins after the message/greeting has ended).
% Abandoned Calls	The percentage of calls into the call center that are terminated by the persons originating the call before answer by a staff person. (URAC standards measure this as the percentage of calls that disconnect after 30 seconds when a live individual would have answered the call. If there is a pre-recorded message or greeting for the caller, the 30-second measurement begins after the message/greeting has ended)
Average Speed to Answer (seconds)	The average delay in seconds that inbound telephone calls encounter waiting in the telephone queue of a call center before answer by a staff person (URAC measures the speed of answer starting at the point when a live individual would have answered the call. If there is a pre-recorded message or greeting for the caller, the time it takes to respond to the call – average speed of answer – begins after the message/greeting has ended).
Highest Maximum Delay (minutes)	The one call during the reporting period that had the greatest delay in speed to answer measured in minutes.
% Calls Answered on or before 4th Ring	The percentage of calls answered on or before the fourth ring.
% Calls Receiving Busy Signal	The percentage of incoming telephone calls 'blocked' or not completed because switching or transmission capacity is unavailable, as compared to the total number of calls encountered. Blocked calls usually occur during peak call volume periods and result in callers receiving a busy signal.
% Calls Answered within 30 Seconds	The percentage of calls answered within thirty seconds.
Average Length of Call (minutes)	The average length of all calls answered measured in minutes.

Column Label	Description
Total All Incoming Calls/VDN	Report a total for all incoming calls to the Main/Trunk line.
<name of split>	A separate column needs to be added to the report for each individual Split/VDN maintained for the Main/Trunk line.
mm/yyyy	The reporting period represented by a two character number for the month (mm) and a four character number for the year (yyyy). Example: January 2012 would be represented as 01/2012.

Report#:	12A	Created:	02/06/2012
Name:	Geo Access Network Reports and Maps	Last Revised:	
Group:	Access/Delivery Network	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	Ongoing		
Due Date:	July 31st		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO's should provide the GEO Access Network Reports and Maps on an annual basis or upon request by the Department.

Sample Layout:

Title page, table of contents, accessibility standard comparison, accessibility standard detail, accessibility detail, accessibility summary, member map, provider listing, provider map, service area detail.

Maps shall include geographic detail including highways, major streets and the boundaries of the MCO's network. In addition to the maps and charts, the MCO shall provide an analysis of the capacity to serve all categories of Members. The analysis shall address the standards for access to care. Maps shall include the location of all categories of Providers or provider sites as follows:

A. Primary Care Providers (designated by a "P");
B. Primary Care Centers, non FQHC and RHC (designated by a "C");
C. Dentists (designated by a "D");
D. Other Specialty Providers (designated by a "S");
E. Non-Physician Providers - including nurse practitioners, (designated by a "N") nurse mid-wives (designated by a "M") and physician assistants (designated by a "A");
F. Hospitals (designated by a "H");
G. After hours Urgent Care Centers (designated by a "U");
H. Local health departments (designated by a "L");
I. Federally Qualified Health Centers/Rural Health Clinics (designated by a "F" or "R" respectively);
J. Pharmacies (designated by a "X");
K. Family Planning Clinics (designated by an "Z");
L. Significant traditional Providers (designated by an "*");
M. Maternity Care Physicians (designated by a "O");
N. Vision Providers (designated by a "V"); and
O. Community Mental Health Centers (designated by an "M").

Report#:	13	Created:	02/06/2012
Name:	Access and Delivery Network Narrative	Last Revised:	
Group:	Access/Delivery Network	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description: MCOs should provide specific information on Access Issues/Problems Identified on the nature of any access problems identified and any plans or remedial action taken.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 13: Access and Delivery Network Narrative

MCO Name: **DMS Use Only**

Report Date: Received Date:
Report Period From: Reviewed Date:
Report Period To: Reviewer:

1. Summary of Complaints - Access Issues

   A. Provider
   B. Member

2. Network Access Problems

   A. Issue
   B. Remedial Action Taken

Report #:	16	Created:	12/12/2011
Name:	Summary of Quality Improvement Activities; Monitoring Indicators,	Last Revised:	06/15/18
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	State Fiscal Year: 01-JULY through 30-JUNE		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description: 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. Include a narrative on the MCO'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.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 16: Summary of Quality Improvement Activities; Monitoring Indicators, Benchmarks and Outcomes

MCO Name:	**DMS Use Only**
Report Date:	Received Date:
Report Period From:	Reviewed Date:
Report Period To:	Reviewer:

MCO completed the following activities during the year:

A. Improving Availability
B. Continuity
C. Quality of Services
D. Monitoring
E. Benchmarks
F. Outcome

Report #:	17	Created:	01/09/2012
Name:	Quality Assessment and Performance Improvement Work Plan; Utilization of Subpopulations	Last Revised:	06/15/2018
Group:	Quality Assurance and Improvement	Report Status:	A
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO shall have a written Quality Assessment and Performance Improvement Work Plan (QAPI) Work Plan that outlines the scope of activities and the goals, objectives and timelines for the QAPI program. New goals and objectives must be set at least annually based on findings from quality improvement activities and studies, survey results, Grievances and Appeals, performance measures and EQRO findings. The MCO is accountable to the Department for the quality of care provided to Members. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI program and annual QAPI work plan; designation of an accountable entity within the organization to provide direct oversight of QAPI; review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made; review on an annual basis of the QAPI program; and modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization. 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 sup-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.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 17: Quality Assessment and Performance Improvement Work Plan; Utilization of Subpopulations and Individuals with Special Healthcare Needs

MCO Name: **DMS Use Only**

Report Date: Received Date:
Report Period From: Reviewed Date:
Report Period To: Reviewer:

Quality Improvement

A. Improving Availability
B. Continuity
C. Quality of Services

Following Outreach/Education to Special Populations (population examples):

A. Children with Special Healthcare Needs
B. Activities Related to the Homeless Population
C. Foster Care/Out of Home Placement
D. Guardianship
E. Smoking Cessation
F. COPD
G. Asthma
H. Diabetes
I. EPSDT

Report#:	21	Created:	01/13/2012
Name:	MCO Committee Activities	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provide a summary of the any MCO committee activities that met during the reporting period, including changes to the committee structure, if any, and any decisions regarding quality and appropriateness of care. Provide copies of meeting minutes and reports of any special focus groups.

Kentucky Department for Medicaid Services MCO Report # 21: MCO Committee Activities

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

I. Quality and Member Access Committee

A. Committee Structure
B. Committee Decisions (quality and appropriateness of care)
C. Provide list of members on committee

II.Committee Name

A. Committee Structure
B. Committee Decisions (quality and appropriateness of care)
C. Provide list of members on committee

III.Committee Name

A. Committee Structure
B. Committee Decisions (quality and appropriateness of care)
C. Provide list of members on committee

Report#:	22	Created:	01/09/2012
Name:	Satisfaction Survey(s)	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description: Describe results of any satisfaction survey that was conducted by the MCO during the report period, if applicable.

(Note: surveys CAHPS are conducted each year, so this section will be completed one quarter for the providers and one for the members) at a minimum.

Sample Layout:

Kentucky Department for Medicaid Services MCO Report # 22: Satisfaction Survey(s)

MCO Name:

DMS Use Only

Report Date:
Report Period From:
Report Period To:

Received Date:
Reviewed Date:
Reviewer:

I. Satisfaction Survey

A. Population Surveyed
B. Results

Report#:	27	Created:	08/27/2011
Name:	Grievance Activity	Last Revised:	03/01/2015
Group:	Grievance and Appeals	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of the quarter through the last day of the quarter		
Due Date:	By 30 calendar days following the last day of the reporting period		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Report provides summarized activity for both Member Grievances and Provider Grievances voiced to the MCO during the reporting period. Grievance means the definition established in 42 CFR 438.400. MCOs are to report:

All Grievances received during the reporting period;
All Grievances received in prior periods that are resolved in the reporting period; All Grievances received in prior periods that have not been resolved.

Sample Layout:

Medicaid ID	Date Grievance Received	Date Acknowledgement Letter Sent	Reason for Grievance	Pending	14 Day Extension Granted	Date Extension Letter Sent	Date Completed	Number of Days Open	Grievance Resolved	Date Resolution Letter Sent	Timely Resolution	Reason Late/ Comments

Provider NPI Provider ID	Date Grievance Received	Date Acknowledgement Letter Sent	Reason for Grievance	Pending	14 Day Extension Granted	Date Extension Letter Sent	Date Completed	Number of Days Open	Grievance Resolved	Date Resolution Letter Sent	Timely Resolution	Reason Late/ Comments

Reporting Criteria:

Terminology	Definition
Date Format	All report dates not otherwise specified are to be in the following format: yyyy/mm/dd.

Row Label	Description
NA	NA

Column Label	Description
Member	Member initiated grievances are to be reported under the Member Tab
Provider	Provider initiated grievances are to be reported under the Provider Tab.
Medicaid ID	Member's Medicaid Identification Number
NPI	National Provider's Identification Number. Atypical Providers use their Kentucky Provider's Medicaid Identification Number.
Date Grievance Received	Date grievance received by MCO
Date Acknowledgement Letter Sent	Date MCO mailed grievant written acknowledgment letter.
Reason for Grievance	List the specific issue of dissatisfaction the grievant voiced. If a grievance includes more than one issue then report each issue separately as an individual grievance.
Pending	Grievances that are not resolved within the reporting period are carried over to the next reporting period as "pending". Valid values are "yes" or "no."
14 Day Extension Granted	Indicate if the MCO granted a 14 calendar day extension, at the request of the grievant or at the decision of the MCO. Valid values are "yes," "no" or "N/A."
Date Extension Letter Sent	Date MCO mailed grievant written extension letter.
Date Grievance Resolved	Date grievance is resolved by the MCO. Valid values are "date" or "N/A."

Number of Days Open	Total number of calendar days the grievance is opened. For a grievance that is pending, it is measured as date grievance received to the end of the reporting period. For a resolved grievance, it is measured as date grievance received through date grievance is resolved.
Grievance Resolved	Grievance status on the last day of the reporting period.
Date Resolution Letter Sent	Date MCO mailed grievant written resolution letter.
Timely Resolution	Grievances resolved over 30 calendar days or in 44 days if an extension has been granted. Valid values are "yes," "no" or "N/A."
Reason Late/Comments	MCO explanation for delayed resolution. MCO Comments.

Report#:	27B KY HEALTH	Created:	08/27/2011
Name:	Grievance Activity	Last Revised:	05/29/2018
Group:	Grievance and Appeals	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of the quarter through the last day of the quarter		
Due Date:	By 30 calendar days following the last day of the reporting period		
Submit To:	Kentucky Department for Medicaid Services		

Description:

KY HEALTH Report provides summarized activity for both Member Grievances and Provider Grievances voiced to the MCO during the reporting period.

Grievance means the definition established in 42 CFR 438.400. MCOs are to report:

All Grievances received during the reporting period;
All Grievances received in prior periods that are resolved in the reporting period; All Grievances received in prior periods that have not been resolved.

Sample Layout:

Medicaid ID	Date Grievance Received	Date Acknowledgement Letter Sent	Reason for Grievance	Pending	14 Day Extension Granted	Date Extension Letter Sent	Date Completed	Number of Days Open	Grievance Resolved	Date Resolution Letter Sent	Timely Resolution	Reason Late/ Comments

Provider NPI Provider ID	Date Grievance Received	Date Acknowledgement Letter Sent	Reason for Grievance	Pending	14 Day Extension Granted	Date Extension Letter Sent	Date Completed	Number of Days Open	Grievance Resolved	Date Resolution Letter Sent	Timely Resolution	Reason Late/ Comments

Reporting Criteria:

Terminology	Definition
Date Format	All report dates not otherwise specified are to be in the following format: yyyy/mm/dd.

Row Label	Description
NA	NA

Column Label	Description
Member	Member initiated grievances are to be reported under the Member Tab
Provider	Provider initiated grievances are to be reported under the Provider Tab.
Medicaid ID	Member's Medicaid Identification Number
NPI	National Provider's Identification Number. Atypical Providers use their Kentucky Provider's Medicaid Identification Number.
Date Grievance Received	Date grievance received by MCO
Date Acknowledgement Letter Sent	Date MCO mailed grievant written acknowledgment letter.
Reason for Grievance	List the specific issue of dissatisfaction the grievant voiced. If a grievance includes more than one issue then report each issue separately as an individual grievance.
Pending	Grievances that are not resolved within the reporting period are carried over to the next reporting period as "pending". Valid values are "yes" or "no."
14 Day Extension Granted	Indicate if the MCO granted a 14 calendar day extension, at the request of the grievant or at the decision of the MCO. Valid values are "yes," "no" or "N/A."
Date Extension Letter Sent	Date MCO mailed grievant written extension letter.
Date Grievance Resolved	Date grievance is resolved by the MCO. Valid values are "date" or "N/A."
Number of Days Open	Total number of calendar days the grievance is opened. For a grievance that is pending, it is measured as date grievance received to the end of the reporting period. For a resolved grievance, it is measured as date grievance received through date grievance is resolved.
Grievance Resolved	Grievance status on the last day of the reporting period.

Date Resolution Letter Sent	Date MCO mailed grievant written resolution letter.
Timely Resolution	Grievances resolved over 30 calendar days or in 44 days if an extension has been granted. Valid values are "yes," "no" or "N/A."
Reason Late/comments	MCO explanation for delayed resolution. MCO Comments.

Report #:	28	Created:	08/27/2011
Name:	Appeal Activity	Last Revised:	10/12/2011
Group:	Member and Financial	Report Status:	Active
Frequency:	Quarterly	Exhibits:	A, B, D
Period:	First day of the quarter through the last day of the quarter		
Due Date:	By 30 calendar days following the last day of the reporting period		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Report provides a summarized activity for both Member and Provider Appeals during the reporting period. Member appeals are based on Category of Service (COS) while Provider Appeals are based on Billing Provider Type/Category.

Two (2) Billing Provider Types are further broken down as follows:

1. Billing Provider Type 01 General Hospital
   a. Inpatient;
   b. Outpatient;
   c. Emergency Room; and
   d. Inpatient/Outpatient Other
2. Billing Provider Type 54 Pharmacy
   a. Pharmacy non-Behavioral Health Brand;
   b. Pharmacy non-Behavioral Health Generic;
   c. Pharmacy Behavioral Health Brand; and
   d. Pharmacy Behavioral Health Generic

An appeal submitted by a Provider on the Member's behalf is to be reported under Member Appeal Activity.

Sample Layout:

Member Appeal Activity

COS	Category of Service (COS) Description	Beginning Balance	Ending Balance **

Member Appeal Activity

Received					
Total	Expedited		Non Expedited		
	Oral	Written	Oral	Written	5 Working Days Written Notice Provided

Resolved

Total	Expedite Resolved in 3 Working Days	Non Expedited Resolved in 30 Calendar Days *	Non Expedited Average Days for Resolution	Written Notice of Resolution within 30 Calendar Days *

Resolved

Expedited				Non Expedited				
Final Disposition					Final Disposition			
Upheld	Overturned	Partially Overturned	Moved to Non Expedited	Oral Abandoned	Upheld	Overturned	Partially Overturned	Appeals Extended by 14 Calendar Days

Medicaid Mandatory Services

02	Inpatient Hospital	0	0
12	Outpatient Hospital	0	0
32	EPSDT Related	0	0
34	Clinical Social Worker	0	0
37	Physical Therapist Crossover	0	0
38	Occupational Therapist	0	0
39	Psychologist Crossover	0	0
40	DME	0	0
41	Primary Care	0	0
43	Rural Health Clinic	0	0
44	Nurse Midwife	0	0
45	Family Planning	0	0
46	Home Health	0	0
47	Independent Laboratory	0	0
48	EPSDT Preventive	0	0
62	Emergency Transportation	0	0
63	Non-Emergency Transportation	0	0
67	Vision	0	0

72	Dental	0	0
74	Physician	0	0
75	Certified Nurse Practitioner	0	0
81	Hearing	0	0
90	Comp. Outpatient Rehab Facility	0	0
92	Psychiatric Distinct Part Unit	0	0
93	Rehab Distinct Part Unit	0	0
94	Physician Assistant	0	0
	Subtotal: Mandatory Services		

Medicaid Optional Services

03	Mental Hospital	0	0
04	Renal Dialysis Clinic	0	0
08	Psychiatric Residential Treat Facility	0	0
13	Ambulatory Surgery	0	0
16	Impact Plus	0	0
17	Specialized Children's Services Clinic	0	0
20	Targeted Case Management – Adults	0	0
21	Targeted Case Management – Children	0	0
24	Comm. for Child Special Health Needs	0	0
29	Preventive Health	0	0
35	Chiropractor	0	0
36	Other Lab & X-Ray	0	0
42	Community Mental Health Center	0	0
54	Nurse Anesthetist	0	0
55	Hospice – Non Institutional	0	0
64	Pharmacy	0	0
88	Podiatry	0	0
99	Unknown Type	0	0
	Subtotal: Optional Services		
	Total: Mandatory and Optional		

Provider Type/Category	Provider Appeal Activity														
			Received				Resolved								
	Beginning Balance	Ending Balance	Total	Oral	Written	5 Working Days Written Notice	Total	Resolved in 30 Calendar Days	Average Days for Resolution	Written Notice of Resolution	Oral Abandoned	Upheld	Overturned	Partially Overturned	Appeals Extended by 14 Calendar Days
Inpatient															
Outpatient															
Unknown Type															
Total	0	0	0	0	0	0	0		0	0	0	0	0	0	0

Reporting Criteria:

Terminology	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyY

Row Label	**Description**
COS	Two character designation for a state specific category of service. Crosswalk may be found in Exhibit D.
Category of Service (COS) Description	A description for the 'COS'.
Medicaid Mandatory Services	State covered Medicaid services required by federal law.
Subtotal: Mandatory Services	Calculated field. Sum total of all services listed as mandatory services For columns with Average Days it is the average days of resolution for all mandatory services.
Medicaid Optional Services	State covered Medicaid services in addition to the mandatory covered services the state has chosen to cover.
Subtotal: Optional Services	Calculated field. Sum total of all services listed as optional services. For columns with Average Days it is the average days of resolution for all optional services.
Total: Mandatory and Optional	Calculated field. Total of all mandatory and optional services. For columns with Average Days it is the average days of resolution for all mandatory and optional services.
Provider Type/Category	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk. Crosswalk of Provider Type Categories for General Hospital and Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Total	Calculated field. Total of all Provider Type/Category listed in the report. For columns with Average Days it is the average days of resolution for all Provider Type/Category listed in the report.

Column Label	**Description**
Member: Beginning Balance	Total number of outstanding appeals at the beginning of the first day of the reporting period.
Member: Ending Balance	Total number of outstanding appeals at the end of the last day of the reporting period.
Member: Received: Total	Total number of appeals received during the reporting period.
Member: Received: Expedited	Total number of expedited appeals received within the reporting period broken down by Oral and Written.
Member: Received: Expedited: Oral	Total number of expedited oral appeals received within the reporting period.
Member: Received: Expedited: Written	Total number of expedited written appeals received within the reporting period.
Member: Received: Non Expedited	Total number of non-expedited appeals received within the reporting period broken down by Oral and Written.
Member: Received: Non Expedited: Oral	Total number of non-expedited oral appeals received within the reporting period.
Member: Received: Non Expedited: Written	Total number of non-expedited written appeals received within the reporting period.
Member: Received: Non Expedited: 5 Working Days Written Notice Provided	Total number of written notices provided within five (5) working days for non-expedited appeals.

Member: Resolved: Total	Total number of appeals resolved during the reporting period.
Member: Resolved: Expedited Resolved in 3 Working Days	Total of expedited appeals resolved in three (3) or fewer working days.
Member: Resolved: Non Expedited Resolved in 30 Calendar Days	Total of non-expedited appeals resolved in thirty (30) or fewer calendar days.
Member: Resolved: Non Expedited	Average number of days to resolve all non-expedited appeals excluding non-

Average Days for Resolution	expedited appeals extended by fourteen (14) calendar days.
Member: Resolved: Written Notice of Resolution within 30 Calendar Days	Total number of written notice of resolution that were provided within thirty (30) calendar days of receipt of a non-expedited appeal.
Member: Resolved: Expedited	An appeal that is required to be resolved within three (3) calendar days).
Member: Resolved: Final Disposition	Result of the expedited or non-expedited appeal process broken down by upheld, overturned and partially overturned.
Member: Resolved: Expedited: Final Disposition: Upheld	Total number of expedited appeals that were resolved during the reporting period and were upheld. Upheld means that the prior decision was confirmed and remains as is.
Member: Resolved: Expedited: Final disposition: Overturned	Total number of expedited appeals that were resolved during the reporting period and were overturned. Overturned means that the prior decision was not confirmed and was reversed.
Member: resolved: Expedited: Final disposition: Partially Overturned	Total number of expedited appeals that were resolved during the reporting period and were partially overturned. Partially overturned means that part of the prior decision was not confirmed and was reversed.
Member: Resolved: Expedited: Moved to Non Expedited	Number of expedited appeals that moved to a non-expedited appeal process.
Member: Resolved: Non Expedited: Oral Abandoned	A non-expedited appeal that was not followed up by a written appeal and no additional action was taken.
Member: Resolved: Non Expedited: Final Disposition: Upheld	Total number of non-expedited appeals that were resolved during the reporting period and were upheld. Upheld means that the prior decision was confirmed and remains as is.
Member: Resolved: Non Expedited: Final Disposition: Overturned	Total number of non-expedited appeals that were resolved during the reporting period and were overturned. Overturned means that the prior decision was not confirmed and was reversed.
Member: Resolved: Non Expedited: Final Disposition: Partially Overturned	Total number of non-expedited appeals that were resolved during the reporting period and were partially overturned. Partially overturned means that part of the prior decision was not confirmed and was reversed.
Member: Appeals Extended by 14 Calendar Days	The total number of non-expedited appeals that were extended by fourteen (14) calendar days beyond the initial thirty (30) calendars day period.
Provider: Beginning Balance	Total number of outstanding appeals at the beginning of the first day of the reporting period.
Provider: Ending Balance	Total number of outstanding appeals at the end of the last day of the reporting period.
Provider: Received: Total	Total number of appeals received during the reporting period.
Provider: Received: Oral	Total number of oral appeals received within the reporting period.
Provider: Received: Written	Total number of written appeals received within the reporting period.
Provider: Received: 5 Working Days Written Notice Provided	Total number of written notices provided within five (5) working days.
Provider: Resolved: Total	Total number of appeals resolved during the reporting period.
Provider: Resolved: Resolved in 30 Calendar Days	Total number of appeals resolved in thirty (30) or fewer calendar days.
Provider: Resolved: Average Days for Resolution	Average number of days to resolve all appeals excluding appeals extended by fourteen (14) calendar days.
Provider: Resolved: Written Notice of Resolution within 30 Calendar Days	Total number of written notice of resolution that were provided within thirty (30) calendar days of receipt of a non-expedited appeal.
Provider: Resolved: Oral Abandoned	An oral appeal that was not followed up by a written appeal and no additional action was taken.
Provider: Resolved: Upheld	Total number of appeals that were resolved during the reporting period and were upheld. Upheld means that the prior decision was confirmed and remains as is.

Provider: Resolved: Overturned	Total number of appeals that were resolved during the reporting period and were overturned. Overturned means that the prior decision was not confirmed and was reversed.
Provider: Resolved: Partially Overturned	Total number of appeals that were resolved during the reporting period and were partially overturned. Partially overturned means that part of the prior decision was not confirmed and was reversed.
Provider: Appeals Extended by 14 Calendar Days	The total number of appeals that were extended by fourteen (14) calendar days beyond the initial thirty (30) calendar day period.

Report #:	28B KY HEALTH	Created:	05/29/2018
Name:	Appeal Activity	Last Revised:	10/12/2011
Group:	Member and Financial	Report Status:	Active
Frequency:	Quarterly	Exhibits:	A, B, D
Period:	First day of the quarter through the last day of the quarter		
Due Date:	By 30 calendar days following the last day of the reporting period		
Submit To:	Kentucky Department for Medicaid Services		

Description:

KY HEALTH Report provides a summarized activity for both Member and Provider Appeals during the reporting period. Member appeals are based on Category of Service (COS) while Provider Appeals are based on Billing Provider Type/Category.

Two (2) Billing Provider Types are further broken down as follows:

I. Billing Provider Type 01 General Hospital
- A. Inpatient;
- B. Outpatient;
- C. Emergency Room; and
- D. Inpatient/Outpatient Other

II. Billing Provider Type 54 Pharmacy
- A. Pharmacy non-Behavioral Health Brand;
- B. Pharmacy non-Behavioral Health Generic;
- C. Pharmacy Behavioral Health Brand; and
- D. Pharmacy Behavioral Health Generic

An appeal submitted by a Provider on the Member's behalf is to be reported under Member Appeal Activity.

Sample Layout:

Member Appeal Activity

COS	Category of Service (COS) Description	Beginning Balance	Ending Balance **

Member Appeal Activity

Received					
Total	Expedited		Non Expedited		
	Oral	Written	Oral	Written	5 Working Days Written Notice Provided

Resolved

Total	Expedite Resolved in 3 Working Days	Non Expedited Resolved in 30 Calendar Days *	Non Expedited Average Days for Resolution	Written Notice of Resolution within 30 Calendar Days *

Resolved

Expedited				Non Expedited				
Final Disposition					Final Disposition			
Upheld	Overturned	Partially Overturned	Moved to Non Expedited	Oral Abandoned	Upheld	Overturned	Partially Overturned	Appeals Extended by 14 Calendar Days

Medicaid Mandatory Services

02	Inpatient Hospital	0	0
12	Outpatient Hospital	0	0
32	EPSDT Related	0	0
34	Clinical Social Worker	0	0
37	Physical Therapist Crossover	0	0
38	Occupational Therapist	0	0
39	Psychologist Crossover	0	0
40	DME	0	0
41	Primary Care	0	0
43	Rural Health Clinic	0	0
44	Nurse Midwife	0	0
45	Family Planning	0	0
46	Home Health	0	0
47	Independent Laboratory	0	0
48	EPSDT Preventive	0	0
62	Emergency Transportation	0	0
63	Non-Emergency Transportation	0	0
67	Vision	0	0
72	Dental	0	0

74	Physician	0	0
75	Certified Nurse Practitioner	0	0
81	Hearing	0	0
90	Comp. Outpatient Rehab Facility	0	0
92	Psychiatric Distinct Part Unit	0	0
93	Rehab Distinct Part Unit	0	0
94	Physician Assistant	0	0
	Subtotal: Mandatory Services		

Medicaid Optional Services

03	Mental Hospital	0	0
04	Renal Dialysis Clinic	0	0
08	Psychiatric Residential Treat Facility	0	0
13	Ambulatory Surgery	0	0
16	Impact Plus	0	0
17	Specialized Children's Services Clinic	0	0
20	Targeted Case Management – Adults	0	0
21	Targeted Case Management – Children	0	0
24	Comm. for Child Special Health Needs	0	0
29	Preventive Health	0	0
35	Chiropractor	0	0
36	Other Lab & X-Ray	0	0
42	Community Mental Health Center	0	0
54	Nurse Anesthetist	0	0
55	Hospice – Non Institutional	0	0
64	Pharmacy	0	0
88	Podiatry	0	0
99	Unknown Type	0	0
	Subtotal: Optional Services		
	Total: Mandatory and Optional		

Provider Type/Category	Provider Appeal Activity														
			Received				Resolved								
	Beginning Balance	Ending Balance	Total	Oral	Written	5 Working Days Written Notice	Total	Resolved in 30 Calendar Days	Average Days for Resolution	Written Notice of Resolution	Oral Abandoned	Upheld	Overturned	Partially Overturned	Appeals Extended by 14 Calendar Days
Inpatient															
Outpatient															
Unknown Type															
Total	0	0	0	0	0	0	0		0	0	0	0	0	0	0

Reporting Criteria:

Terminology	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyY

Row Label	**Description**
COS	Two character designation for a state specific category of service. Crosswalk may be found in Exhibit D.
Category of Service (COS) Description	A description for the 'COS'.
Medicaid Mandatory Services	State covered Medicaid services required by federal law.
Subtotal: Mandatory Services	Calculated field. Sum total of all services listed as mandatory services For columns with Average Days it is the average days of resolution for all mandatory services.
Medicaid Optional Services	State covered Medicaid services in addition to the mandatory covered services the state has chosen to cover.
Subtotal: Optional Services	Calculated field. Sum total of all services listed as optional services. For columns with Average Days it is the average days of resolution for all optional services.
Total: Mandatory and Optional	Calculated field. Total of all mandatory and optional services. For columns with Average Days it is the average days of resolution for all mandatory and optional services.
Provider Type/Category	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk. Crosswalk of Provider Type Categories for General Hospital and Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Total	Calculated field. Total of all Provider Type/Category listed in the report. For columns with Average Days it is the average days of resolution for all Provider Type/Category listed in the report.

Column Label	Description
Member: Beginning Balance	Total number of outstanding appeals at the beginning of the first day of the reporting period.
Member: Ending Balance	Total number of outstanding appeals at the end of the last day of the reporting period.
Member: Received: Total	Total number of appeals received during the reporting period.
Member: Received: Expedited	Total number of expedited appeals received within the reporting period broken down by Oral and Written.
Member: Received: Expedited: Oral	Total number of expedited oral appeals received within the reporting period.
Member: Received: Expedited: Written	Total number of expedited written appeals received within the reporting period.
Member: Received: Non Expedited	Total number of non-expedited appeals received within the reporting period broken down by Oral and Written.
Member: Received: Non Expedited: Oral	Total number of non-expedited oral appeals received within the reporting period.
Member: Received: Non Expedited: Written	Total number of non-expedited written appeals received within the reporting period.
Member: Received: Non Expedited: 5 Working Days Written Notice Provided	Total number of written notices provided within five (5) working days for non-expedited appeals.
Member: Resolved: Total	Total number of appeals resolved during the reporting period.
Member: Resolved: Expedited Resolved in 3 Working Days	Total of expedited appeals resolved in three (3) or fewer working days.
Member: Resolved: Non Expedited Resolved in 30 Calendar Days	Total of non-expedited appeals resolved in thirty (30) or fewer calendar days.
Member: Resolved: Non Expedited	Average number of days to resolve all non-expedited appeals excluding non-

Average Days for Resolution	expedited appeals extended by fourteen (14) calendar days.
Member: Resolved: Written Notice of Resolution within 30 Calendar Days	Total number of written notice of resolution that were provided within thirty (30) calendar days of receipt of a non-expedited appeal.
Member: Resolved: Expedited	An appeal that is required to be resolved within three (3) calendar days).
Member: Resolved: Final Disposition	Result of the expedited or non-expedited appeal process broken down by upheld, overturned and partially overturned.
Member: Resolved: Expedited: Final Disposition: Upheld	Total number of expedited appeals that were resolved during the reporting period and were upheld. Upheld means that the prior decision was confirmed and remains as is.
Member: Resolved: Expedited: Final disposition: Overturned	Total number of expedited appeals that were resolved during the reporting period and were overturned. Overturned means that the prior decision was not confirmed and was reversed.
Member: resolved: Expedited: Final disposition: Partially Overturned	Total number of expedited appeals that were resolved during the reporting period and were partially overturned. Partially overturned means that part of the prior decision was not confirmed and was reversed.
Member: Resolved: Expedited: Moved to Non Expedited	Number of expedited appeals that moved to a non-expedited appeal process.
Member: Resolved: Non Expedited: Oral Abandoned	A non-expedited appeal that was not followed up by a written appeal and no additional action was taken.
Member: Resolved: Non Expedited: Final Disposition: Upheld	Total number of non-expedited appeals that were resolved during the reporting period and were upheld. Upheld means that the prior decision was confirmed and remains as is.
Member: Resolved: Non Expedited: Final Disposition: Overturned	Total number of non-expedited appeals that were resolved during the reporting period and were overturned. Overturned means that the prior decision was not confirmed and was reversed.
Member: Resolved: Non Expedited: Final Disposition: Partially Overturned	Total number of non-expedited appeals that were resolved during the reporting period and were partially overturned. Partially overturned means that part of the prior decision was not confirmed and was reversed.
Member: Appeals Extended by 14 Calendar Days	The total number of non-expedited appeals that were extended by fourteen (14) calendar days beyond the initial thirty (30) calendars day period.
Provider: Beginning Balance	Total number of outstanding appeals at the beginning of the first day of the reporting period.

Provider: Ending Balance	Total number of outstanding appeals at the end of the last day of the reporting period.
Provider: Received: Total	Total number of appeals received during the reporting period.
Provider: Received: Oral	Total number of oral appeals received within the reporting period.
Provider: Received: Written	Total number of written appeals received within the reporting period.
Provider: Received: 5 Working Days Written Notice Provided	Total number of written notices provided within five (5) working days.
Provider: Resolved: Total	Total number of appeals resolved during the reporting period.
Provider: Resolved: Resolved in 30 Calendar Days	Total number of appeals resolved in thirty (30) or fewer calendar days.
Provider: Resolved: Average Days for Resolution	Average number of days to resolve all appeals excluding appeals extended by fourteen (14) calendar days.
Provider: Resolved: Written Notice of Resolution within 30 Calendar Days	Total number of written notice of resolution that were provided within thirty (30) calendar days of receipt of a non-expedited appeal.
Provider: Resolved: Oral Abandoned	An oral appeal that was not followed up by a written appeal and no additional action was taken.
Provider: Resolved: Upheld	Total number of appeals that were resolved during the reporting period and were upheld. Upheld means that the prior decision was confirmed and remains as is.

Provider: Resolved: Overturned	Total number of appeals that were resolved during the reporting period and were overturned. Overturned means that the prior decision was not confirmed and was reversed.
Provider: Resolved: Partially Overturned	Total number of appeals that were resolved during the reporting period and were partially overturned. Partially overturned means that part of the prior decision was not confirmed and was reversed.
Provider: Appeals Extended by 14 Calendar Days	The total number of appeals that were extended by fourteen (14) calendar days beyond the initial thirty (30) calendar day period.

Report#:	29	Created:	02/06/2012
Name:	Grievances and Appeals Narrative	Last Revised:	
Group:	Grievances and Appeals	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Discuss any trends or problem areas identified in the appeals and grievance and address opportunity for improvement.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report #29: Grievances and Appeals Narrative

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

Member Grievances

Trends
Problems or Issues Identified
Opportunity for Improvement

Provider Grievances

Trends
Problems or Issues Identified
Opportunity for Improvement

Member Appeals

Trends
Problems or Issues Identified
Opportunity for Improvement

Provider Appeals

Trends
Problems or Issues Identified
Opportunity for Improvement

Report #:	38	Created:	01/22/2019
Name:	Behavioral Health Services In/Out State Facility Utilization	Last Revised:	
Group:	Utilization	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15h of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:
MCO should provide Special Services. Report will contain Behavioral Health services placement information for members. This report should identify in and out of state BH facility utilization for all members under age 21. The report should include ALL members under age 21 that are in a facility for 10 days or more in and out of the state of KY for a BH service no matter what service they are receiving. If the member is in a facility and receiving an EPSDT Special Service, it should be reported.

Reporting Criteria:

General Specifications	Definition
Sort Order	The report is to be sorted in order: Facility Name (A to Z); Member last name (A to Z).

Column Label	Description
Member Last Name	The Member's last name
Member First Name	The Member's first name
Member Medicaid ID	The Member's Medicaid ID number
Facility NPI Number	The Facility's NPI number
Facility Name	The complete name of the facility
Facility State	The 2 digit postal abbreviation of the state where the facility is located
Level of Care	The amount of assistance a member requires to meet their needs. Examples: Inpatient, PRTF, ECU, Substance Abuse
Date of Admission	The date the member was admitted. Use mm/dd/yyyy
Admitting Diagnosis	The primary diagnosis
Foster Care Indicator	The member's foster care status. Acceptable entries are Y and N
Date of Last Review	The date of the last review to determine continuation of current services. Use mm/dd/yyyy
Discharge Date	The date the member was/is to be discharged from the current level of care. If unknown, leave blank.
Discharge Disposition	The code for anticipated placement when the Member is discharged from the current level of care. Acceptable entries are: 1 - Bio Home; 2 – Foster Parents; 3 – PRTF/Residential; 4 – AMA; 5 – TFC (Therapeutic Foster Care); 6 - CSU (Crisis Stabilization Unit); 7 - ECU (Extended Care Unit); 8 Continues Inpatient
Aftercare	The type of facility providing care after discharge. Acceptable entries are: 1 – PRTF; 2 – Residential; 3 – Outpatient CMHC; 4 – Outpatient Non-CHMC; 5 – None; 6-DCBS Placement

Date of De-Certification	The date the member was/is to be De-Certification from the current level of care. If unknown, leave blank
Facilities Discharge Recommended Level of Care	The Facilities Discharge Recommended Level of Care
Appeal Filed by Agency=Yes or No; Results of Appeal	Yes or No to Appeal Filed by Agency; If Yes the results of the appeal

Sample Layout:

Member Last Name	Member First Name	Member Medicaid #	Facility NPI #	Facility Name	Facility State	Level of Care	Date of Admission	Admitting Diagnosis	Foster Care Status	Date of Last Review	Discharge Date	Discharge Disposition	Aftercare	Date of De-Certification	Facilities Discharge Recommended Level of Care	Appeal Filed by Agency=Yes or No; Results of Appeal

Report#:	39	Created:	01/04/2012
Name:	Monthly Formulary Management Report	Last Revised:	02/07/2012
Group:	Pharmacy	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Monthly summary of pharmacy related utilization and costs by Medicaid members assigned to Managed Care Organizations broken down by region.

Sample Layout:

		NOV-11	DEC-11	JAN-12	%CHANGE PER MONTH	%CHANGE PER YEAR	AVERAGE PER MONTH	Y-T-D
STATISTI	NEW RXS							
	REFILL RXS							
	TOTAL NON PDL RXS							
	% NON PDL RXS							
	PSYCH RXS							
	% PSYCH RXS							
	NON PDL PSYCH RXS							
	% NON PDL PSYCH RXS							
	# PSYCH UTILIZERS							
	% PSYCH UTILIZERS							
	% PSYCH UTILIZERS/RX UTILIZERS							
	# PSYCH RXS/MEMBER							
	# PSYCH RXS/PSYCH UTILIZER							
	#RXS/MEMBER LESS PSYCHS							
	% MEMBERS ON MEDS LESS PSYCHS							
	PSYCH COST/PSYCH UTILIZER							
	# PROVIDER PRESCRIBED OTCS							
	#CONTROLLED RXS							
	% BRAND							
	% GENERIC							
BEHAVIORAL HEALTH	% ATYP ANTIPSYCH UTILIZERS							
	% MEMBERS ON ATYP ANTIPSYCHS/RX UTILIZERS							

	# TYPICAL ANTIPSYCH UTILIZERS							
	% TYPICAL							

	ANTIPSYCH UTILIZERS							
	# MEMBERS ON ATYP TO TYP							
	BH % BRAND							
	BH % GENERIC							
PERCENTAGES	% PDL COST/TOTAL COST							
	% NON PDL COST/TOTAL COST							
	% PSYCH COST/TOTAL COST							
	% PDL PSYCH COST/TOTAL COST							
	% NON PDL PSYCH COST/TOTAL COST							
	% ATYP ANTIPSYCH COST/TOTAL COST							
	% HIV COST/TOTAL COST							
	% HEP B COST/TOTAL COST							
	% HEP C COST/TOTAL COST							
SPECIALTY	HEP C RXS							
	# HEP C UTILIZERS							
	HEP C RX COST							
	HEP C COST/HEP C UTILIZER							
	HEP B RXS							
	# HEP B UTILIZERS							
	HEP B RX COST							
	HEP B COST/HEP B UTILIZER							

	HEP B COST/MEMBER							
	HIV RXS							
	#HIV UTILIZER							
	HIV RX COST							
	HIVCOST/HIV UTILIZER							
COST	TOTAL COST							
	DRUG REIMBURSEMENT							
	DISPENSINGFEES							
	TOTAL COST/MEMBER							
	COST/RX UTILIZER							
	PDL TOTAL COST							
	PDL COST/MEMBER							
	NON PDL TOTAL COST							
	NON PDL COST/MEMBER							
	PSYCH COST							
	PSYCH COST/MEMBER							
	PDL PSYCH COST							
	PDL PSYCH COST/MEMBER							
	NON PDL PSYCH COST							
	NON PDL PSYCH COST/MEMBER							
	ATYPANTIPSY COST							
	ATYPANTIPSY COST/MEMBER							
	ATYPANTIPSYCH COST/ATYP ANTIPSYUTILIZER							
	PROVIDER PRESCRIBEDOTC TOTAL COST							
	PROVIDER PRESCRIBEDOTC COST/MEMBER							
	TOTAL INSULIN COST							

	PROVID3ER PRESCRIBEDOTC COST LESS INSULIN							
	H2BLOCKERS TOTAL COST							

	NSAIDS TOTAL COST							
	PPI TOTAL COST							
	VACCINE TOTAL COST							
TOTAL REGIONS	#MEMBERS							
	%UTILIZERS							
	# RXS							
	AVG # RXS/MEMBER							
	AVG # RXS/UTILIZER							
	# PAs							
	% PAs DENIED							
	#CLAIMS							
	%CLAIMS DENIED							
	#PRESCRIBERS							
	# RXS/PRESCRIBER							
	#CONTROLS/ PRESCRIBER							
	#PHARMACIES							
	AVG COST/RX							
	SUBOXONE RXS							
	ADHD RXS							
	LOCK INS							
REGION 1	#MEMBERS							
	%UTILIZERS							
	# RXS							
	AVG # RXS/MEMBER							
	AVG # RXS/UTILIZER							
	# PAs							
	% PAs DENIED							
	#CLAIMS							
	%CLAIMS DENIED							
	#PRESCRIBERS							
	# RXS/PRESCRIBER							
	#CONTROLS/ PRESCRIBER							
	#PHARMACIES							
	AVG COST/RX							
	SUBOXONE RXS							
	ADHD RXS							

Reporting Criteria:

Terminology	Definition
DateFormat	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Definition
NEW RXS	Number of new prescriptions
REFILL RXS	Number of refill prescriptions
TOTAL NON PDL RXS	Total number of prescriptions written for a drug not listed on the preferred drug list
% NON PDL RXS	Percentage of prescriptions written for a drug not listed on the preferred drug list
PSYCH RXS	Number of prescriptions written for a psychotropic drug
% PSYCH RXS	Percentage of prescriptions written for a drug not listed on the preferred drug list
NON PDL PSYCH RXS	Number of prescriptions written for a psychotropic drug not listed on the preferred drug list
% NON PDL PSYCH RXS	Percentage of prescriptions written for a psychotropic drug not listed on the preferred drug list
# PSYCH UTILIZERS	Number of Medicaid /MCO members for whom psychotropic drug prescriptions were filled
% PSYCH UTILIZERS	Percentage of Medicaid /MCO members for whom psychotropic drug prescriptions were filled
% PSYCH UTILIZERS/RX UTILIZERS	Percentage of Medicaid/MCO members for whom psychotropic drug prescriptions were filled as compared to total Medicaid/MCO members for whom any drug prescriptions were filled
# PSYCH RXS/MEMBER	Number of psychotropic prescriptions per Medicaid/MCO member
# PSYCH RXS/PSYCH UTILIZER	Number of psychotropic prescriptions per Medicaid/MCO member who fills prescriptions written for psychotropic medications
#RXS/MEMBER LESSPSYCHS	Number of prescriptions per Medicaid/MCO member not counting prescriptions for psychotropic medications
%MEMBERS ON MEDS LESS PSYCHS	Percentage of Medicaid/MCO members for whom drug prescriptions were filled not counting prescriptions for psychotropic medications
PSYCHCOST/PSYCH UTILIZER	Psychotropic drug cost/Medicaid/MCO member for whom psychotropic medication were filled
# OTC RXS	Number of prescriptions filled for over the counter items
#CONTROLLED RXS	Number of prescriptions filled for controlled (scheduled) narcotics
% BRAND	Percentage of prescriptions filled with brand name drugs
%GENERIC	Percentage of prescriptions filled with a generic drug
ATYPANTIPSYCH RXS	Number of prescriptions filled for an atypical anti-psychotropic drug
NON PDL ATYP ANTI PSYCH RXS	Number of prescriptions filled for an atypical anti-psychotropic drug not listed on the preferred drug list
#ATYP ANTIPSYCH UTILIZERS	Number of Medicaid/MCO members for whom drug prescriptions for atypical antipsychotics were filled
% ATYP ANTIPSYCH UTILIZERS	Percentage of Medicaid/MCO members for whom drug prescriptions were filled for atypical antipsychotics
%MEMBERS ON ATYP ANTIPSYCHS/RX UTILIZERS	Percentage of Medicaid/MCO members for whom drug prescriptions were filled for atypical antipsychotics as compared to total Medicaid/MCO members for whom any drug prescriptions were filled
# TYPICAL ANTIPSYCH UTILIZERS	Number of Medicaid/MCO members for whom drug prescriptions for typical antipsychotics were filled

% TYPICAL ANTIPSYCH UTILIZERS	Percentage of Medicaid/MCO members for whom drug prescriptions for typical antipsychotics were filled
BH % BRAND	Percentage of behavioral health prescriptions filled with a brand name drug
BH % GENERIC	Percentage of behavioral health prescriptions filled with a generic drug
% PDL COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs on the preferred drug list as compared with total drug cost
% NON PDL COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs on the non-preferred drug list as compared with total drug cost
% PSYCH COST/TOTAL COST	Percentage of drug cost for prescriptions filled with psychotropic drugs as compared with total drug cost
% PDL PSYCH COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs on the preferred drug list as compared with total drug cost
% NON PDL PSYCH COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs not on the preferred drug list as compared with total drug cost
% ATYP ANTIPSYCH COST/TOTAL COST	Percentage of drug cost for prescriptions filled with atypical antipsychotic drugs as compared with total drug cost
% HIV COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs used to treat HIV as compared with total drug cost
% HEP B COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs used to treat Hep B as compared with total drug cost
% HEP C COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs used to treat Hep C as compared with total drug cost
HEP C RXS	Number of prescriptions filled with drugs used to treat Hep C
# HEP C UTILIZERS	Number of Medicaid/MCO members for whom prescriptions for drugs used to treat Hep C are filled
HEP C RX COST	Total cost for prescriptions filled with drugs used to treat Hep C
HEP C COST/HEP C UTILIZER	Cost for prescriptions filled with drugs used to treat Hep C per Medicaid/MCO member for whom prescriptions for drugs used to treat Hep C are filled
HEP B RXS	Number of prescriptions filled with drugs used to treat Hep B
# HEP B UTILIZERS	Number of Medicaid/MCO members for whom prescriptions for drugs used to treat Hep B are filled

HEP B RX COST	Total cost for prescriptions filled with drugs used to treat Hep B
HEP B COST/HEP B UTILIZER	Cost for prescriptions filled with drugs used to treat Hep B per Medicaid/MCO member for whom prescriptions for drugs used to treat Hep B are filled
HIV RXS	Number of prescriptions filled with drugs used to treat HIV
# HIV UTILIZER	Number of Medicaid/MCO members for whom prescriptions for drugs used to treat HIV are filled
HIV RX COST	Total cost for prescriptions filled with drugs with HIV indication
HIV COST/HIV UTILIZER	Cost for prescriptions filled with drugs with HIV indication per Medicaid/MCO member for whom prescriptions for drugs with HIV indication are filled
TOTAL COST	Total drug cost = Total Drug Reimbursement + Dispensing Fees
TOTAL DRUG REIMBURSEMENT	Total reimbursed for drugs dispensed to Medicaid members
DISPENSING FEES	Total dispensing fees to pharmacies
TOTAL COST/MEMBER	Total drug cost per Medicaid/MCO member
COST/RX UTILIZER	Total drug cost per Medicaid/MCO member for whom prescriptions for any drug are filled
PDL TOTAL COST	Total drug cost for prescriptions filled for drugs listed on the preferred drug list

PDL COST/MEMBER	Total drug cost for prescriptions filled for drugs listed on the preferred drug list per Medicaid/MCO member
NON PDL TOTAL COST	Total drug cost for prescriptions filled for drugs not listed on the preferred drug list
NON PDL COST/MEMBER	Total drug cost for prescriptions filled for drugs not listed on the preferred drug list per Medicaid/MCO member
PSYCH COST	Total drug cost for prescriptions filled with psychotropic drugs
PSYCH COST/MEMBER	Total drug cost for prescriptions filled with psychotropic drugs per Medicaid/MCO member
PDL PSYCH COST	Total drug cost for prescriptions filled with psychotropic drugs listed on the preferred drug list
PDL PSYCH COST/MEMBER	Total drug cost for prescriptions filled with psychotropic drugs listed on the preferred drug list per Medicaid/MCO member
NON PDL PSYCH COST	Total drug cost for prescriptions filled with psychotropic drugs not listed on the preferred drug list
NON PDL PSYCH COST/MEMBER	Total drug cost for prescriptions filled with psychotropic drugs not listed on the preferred drug list per Medicaid/MCO member
ATYPANTIPSY COST	Total drug cost for prescriptions filled with atypical antipsychotic drugs
ATYPANTIPSY COST/MEMBER	Total drug cost for prescriptions filled with atypical antipsychotic drugs per Medicaid/MCO member
ATYPANTIPSYCH COST/ATYPANTIPSY UTILIZER	Total drug cost for prescriptions filled with atypical antipsychotic drugs per Medicaid/MCO member for whom prescriptions for atypical antipsychotic drugs are filled
OTC TOTAL COST	Total cost for prescriptions filled for over the counter items
OTC COST/MEMBER	Total cost for prescriptions filled for over the counter items per Medicaid MCO member
TOTAL INSULIN COST	Total cost for prescriptions filled with insulin
OTC COST LESS INSULIN	Total cost for prescriptions filled for over the counter items minus total cost for prescriptions filled with insulin

H2 BLOCKERS TOTAL COST	Total cost for prescriptions filled with any drug listed in the histamine H2 acid reducers drug category
NSAIDS TOTAL COST	Total cost for prescriptions filled with any drug listed in the non-steroidal anti-inflammatory drug category
PPI TOTAL COST	Total cost for prescriptions filled with any drug listed in the proton pump inhibitor drug category
# MEMBERS	Number of Medicaid/MCO members
% UTILIZERS	Percentage of Medicaid/MCO members for whom prescriptions are filled
# RXS	Number of prescriptions filled for Medicaid/MCO members
AVG # RXS/MEMBER	Average number of prescriptions filled for each Medicaid/MCO member
AVG # RXS/UTILIZER	Average number of prescriptions filled for each Medicaid/MCO member for whom prescriptions are filled
# PAs	Number of prior authorizations for drug items requested
% PAs DENIED	Percentage of prior authorization requests denied as compared to total number of prior authorizations requested
# CLAIMS	Number of prescriptions claims
% CLAIMS DENIED	Percentage of prescription claims denied as compared to total number of paid claims
# PRESCRIBERS	Number of Medicaid/MCO providers who prescribed medications for Medicaid/MCO members for whom prescriptions were filled
# RXS/PRESCRIBER	Number of prescriptions filled for Medicaid/MCO members filled for any drug per provider who prescribed medications for Medicaid/MCO members for whom prescriptions were filled

#CONTROLS/ PRESCRIBER	Number of prescriptions filled for controlled (scheduled) narcotics per provider who prescribed medications for Medicaid/MCO members for whom prescriptions were filled
#PHARMACIES	Number of pharmacies where prescriptions were filled for Medicaid/MCO members
AVG COST/RX	Average cost of prescriptions filled for Medicaid/MCO members per prescription filled for Medicaid/MCO members
SUBOXONERXS	Number of Suboxone prescriptions filled for Medicaid/MCO members
ADHD RXS	Number of prescriptions filled with any drug listed in the attention deficit hyperactivity disorder drug category
#LOCK IN MEMBERS	Number of Medicaid/MCO members placed in a Lock In program

Column Label	Description
Nov 11	Information for the entire month
Dec 11	Information for the entire month
Jan 12	Information for the entire month
% Change per Month	The percentage change realized from one rolling month to the next
% Change per Year	The percentage change realized from one rolling year to the next
Average per Month	The average of the requested information per month
Y-T-D	Total of requested information through the last reporting period

Report #	50A, 50B	Created:	01/01/2017
Name:	Post Payment Billing Recovery	Last Revised:	

Group:	Third Party Liability	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Reports all recoveries for monies collected from commercial insurance carriers during the reporting period from claims that were paid prior to the commercial insurance carrier being identified

Report 50A reports all non-pharmacy recoveries; Report 50B reports all pharmacy recoveries.

Sample Layout:

Member Medicaid ID	Member Name	Claim ICN	Insurance Carrier Name	MCO Paid Amount	Amount Recovered

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Column Label	Description
Member Medicaid ID	The Member's Medicaid ID
Member Name	Concatenate the Member's 'Last Name', 'First Name' 'Middle Initial'.
Claim ICN	The MCO claim internal control number for the claim being reported.
Name of Insurance Carrier	The name of the company that issued the insurance policy
MCO Paid Amount	The net amount the claim adjudicated to a paid status.
Amount Recovered	The total amount recovered from the commercial insurance carrier by the MCO.

[redacted]

Report #:	51	Created:	01/09/2012
Name:	Operational Changes	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Identify any operational changes or relevant to the operations of the MCO not otherwise covered during the report period.

Sample Layout:

Kentucky Department for Medicaid Services

MCO Report # 51: Operational Changes

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

I. **Operational Change**

II. **Operational Change**

III. **Operational Change**

Report#:	52	Created:	02/14/2012
Name:	Expenditures Related to MCO's Operations	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should provide the Executive Management's salary, bonus, other compensation, travel and other expenses based upon the reporting period.

Sample Layout:

							Reporting Period	
Category	**Positions**	**Salary**	**Bonus**	**Other Compensation**	**Travel**	**Other Expenses**	**Begin Date**	**End Date**
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							
Executive Management	Sub-Total							
Executive	All other Executives							

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Executive Management	Capable and responsible for the oversight of the entire operation.
Executive Director/CEO	Primary contact and will be authorized to represent the Contractor regarding inquiries pertaining to the contract, will be available during normal business hours, and will have decision-making authority in regard to urgent situations that arise.
Medical Director	Actively involved in all major clinical programs and Quality Improvement components.
Pharmacy Director	Coordinate, manage and oversee the provision of pharmacy services to Members.
Dental Director	Actively involved in all major dental programs.
CFO	Ensure compliance with adopted standards and review expenditures for reasonableness and necessity.
Compliance Director	Maintain current knowledge of Federal and State legislation, Legislative initiatives, and regulations relating to Contractor and oversee the Contractor's compliance with the laws and Contract requirements of the Department. Serve as the primary contact for and facilitate communications between Contractor leadership and the Department relating to Contract compliance issues.
Quality Improvement Director	Responsible for the operation of the Contractor's QAPI Program and any QAPI Program of its subcontractors.

Sub-Total	Provide the subtotal of each of the Executive Management team above
All Other Executives	Provide a total of all other Executive Management as defined in the MCO contract.

Column Label	Description
Salary	Provide the salary of only the Kentucky's line of business. MCO may disclose an estimated allocation based on the time allocated to Kentucky. Information related to the Contractor's ultimate parent company's Executive Management need not be disclosed.
Bonus	Unless guaranteed, or actually paid during the report period, bonuses disclosed may be target amounts for the period disclosed expressed as a percentage of base salary.
Other Compensation	Is limited to other cash compensation actually paid during the reporting period, and may exclude amounts realized or realizable during the period through grant, vesting or exercise of stock options, restricted stock, stock appreciation rights, phantom stock plans, or other long term non-cash incentives.
Travel	Provide the travel of only the Kentucky's line of business. MCO may disclose an estimated allocation based on the time allocated to Kentucky. Information related to the Contractor's ultimate parent company's Executive Management need not be disclosed.
Other Expenses	Provide the other expenses of only the Kentucky's line of business. MCO may disclose an estimated allocation based on the time allocated to Kentucky. Information related to the Contractor's ultimate parent company's Executive Management need not be disclosed.
Begin Date	Provide the begin date of the report period.
End Date	Provide the end date of the report period.

Report #:	53	Created:	09/12/2011
Name:	Prompt Payment	Last Revised:	09/24/2011
Group:	Financial and Information Systems	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	In accordance with DOI requirements.		
Due Date:	Date Submitted to DOI		

Description:

MCOs are required to comply with the Kentucky Department of Insurance (DOI) requirements for prompt payment reporting as referenced in the DOI HIPMC-CP-3 Prompt Payment Reporting Manual. The DOI requires a quarterly submission of the prompt payment report. A copy of the quarterly prompt payment report is required to be submitted to the Department for Medicaid Services (DMS) at the same time the report is submitted to the DOI. Any revisions of the documents submitted to the DOI are also to be submitted to the DMS at the same time.

Report #:	54	Created:	08/28/2011
Name:	COB Savings	Last Revised:	02/27/2015
Group:	Third Party Liability	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Reports all Coordination of Benefit (COB) savings due to other insurance payment, including Medicare, for which the claim submission includes and the MCO processed/paid the claim accordingly. The report is to include claims when the other insurance paid zero dollars because the service was not covered by the other insurance.

Sample Layout:

COB/TBL Saviings

Member Medicaid ID	Member Name	Claim ICN	MCO Paid Amount	COB Amount
Total				

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Total	Provide a total of all reported activity for MCO Paid Amount, COB Amount, Other Insurance Deductible Amount and Other Insurance Co-Pay Amount.

Column Label	Description
Member Medicaid ID	The Member's Medicaid ID
Member Name	Concatenate the Member's 'Last Name', 'First Name' 'Middle Initial'.
Claim ICN	The MCO claim internal control number for the claim being reported.
MCO Paid Amount	The net amount the claim adjudicated to a paid status. Note: When there is a Provider outstanding balance due and the claim payment was reduced by the outstanding balance do not report the payment Financial paid out.
COB Amount	The amount the other insurance paid on the claim.

[redacted]

Report #:	55	Created:	08/28/2011
Name:	Medicare Cost Avoidance	Last Revised:	02/27/2015
Group:	Third Party Liability	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:
Reports the Medicare crossover claims that were denied during the reporting period because the claim was submitted without first having been submitted to Medicare for payment.

Sample Layout:

Medicare Cost Avoidance			
Medicaid Member ID	Member Name	Claim ICN	Amount Denied Due To Medicare
Monthly Total			

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Total	Provide a total of all reported activity for Denied Amount, Medicare Payment, Medicare Deductible and Medicare Coinsurance.

Column Label	Description
Member Medicaid ID	The Member's Medicaid ID
Member Name	Concatenate the Member's 'Last Name', 'First Name' 'Middle Initial'.

Claim ICN	The MCO claim internal control number for the claim being reported.
Denied Amount Due to Medicare	The billed amount the MCO denied due to Medicare coverage.

Report #:	56	Created:	08/28/2011
Name:	non-Medicare Cost Avoidance	Last Revised:	02/27/2015
Group:	Third Party Liability	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report lists the claims that were denied during the reporting period because the claim was submitted without first having been submitted to another Insurer for payment. The report is not to include Medicare crossover claims.

Sample Layout:

Non-Medicare TPL Cost Avoidance			
Medicaid Member ID	Member Name	Claim ICN	Amount Denied Due To Non-Medicare TPL
Monthly Total			

Reporting Criteria:

General Specifications	Definition
DateFormat	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Total	Provide a total of all reported activity for Denied Amount, Other Insurance non-Medicare Payment, Other Insurance non-Medicare Deductible and Other Insurance non-Medicare Coinsurance.

Column Label	Description
Member Medicaid ID	The Member's Medicaid ID
Member Name	Concatenate the Member's 'Last Name', 'First Name' 'Middle Initial'.
Claim ICN	The MCO claim internal control number for the claim being reported.
Denied Amount	The billed amount the MCO denied due to non-Medicare TPL.

Report #:	57	Created:	08/27/2011
Name:	Potential Subrogation	Last Revised:	02/27/2015
Group:	Third Party Liability	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provides report for cases where the MCO's Member has had an accident and there is potential for a liable third party or subrogation claim.

Sample Layout:

Active/Potential Subrogation/Liable Party							
Member Medicaid ID	Member Name	Date of Injury	Attorney/Liable Party Information	Lien/Claim Amount	Recovered Amount	Status/Closed Date	Comments

Reporting Criteria:

General Specifications	Definition
DateFormat	All report dates are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'Member Name'.

Row Label	Description
NA	NA

Column Label	Description
Member Medicaid ID	The Member's Medicaid ID reported as a text string.
Member Name	Concatenate the Medicaid Member's 'Last Name', 'First Name', 'Middle Initial'
Date of Injury	The date of the actual injury/accident.
Attorney/Liable Party Information	The attorney/liable party name, address and contact information.
Lien Claim Amount	The MCO lien or claim amount.
Recovered Amount	The MCO recovered amount from the attorney/liable party.
Status/Closed Date	Awaiting additional funds or Date case closed if applicable
Comments	Regarding pending payment or any special circumstance

Report #:	58	Created:	08/20/2011
Name:	Original Claims Processed	Last Revised:	08/29/2011
Group:	Claims Processing	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, B
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provides the number of original clean claims processed during a reporting period reported by Billing Provider Type and claim status. There are four claim statuses to be included in the report:

Received;
Pay;
Deny; and
Suspended

Two (2) Billing Provider Types are further broken down as follows:

Billing Provider Type 01 General Hospital
Inpatient;
Outpatient;
Emergency Room; and
Inpatient/Outpatient Other

Billing Provider Type 54 Pharmacy
Pharmacy non-Behavioral Health Brand;
Pharmacy non-Behavioral Health Generic;
Pharmacy Behavioral Health Brand; and
Pharmacy Behavioral Health Generic

Sample Layout:

	Claims Received			
	Total Count	Total Processed	Total Charges	Avg. Charges
Total All Claims				
Inpatient				
Outpatient				
Emergency Room				

Inpatient/Outpatient Other				
Mental Hospital				
PRTF				
Specialized Child Svc Clinics				

	Adjudicated to Pay Status					
	Total Count	Percent	Total Charges	Avg. Charges	Total Paid	Avg. Paid
Total All Claims						
Inpatient						
Outpatient						
Emergency Room						
Inpatient/Outpatient Other						
Mental Hospital						
PRTF						
Specialized Child Svc Clinics						

	Adjudicated to Deny Status			
	Total Count	Percent	Total Charges	Avg. Charges
Total All Claims				
Inpatient				
Outpatient				
Emergency Room				
Inpatient/Outpatient Other				
Mental Hospital				
PRTF				
Specialized Child Svc Clinics				

	Placed in Suspended Status			
	Total Count	Percent	Total Charges	Avg. Charges
Total All Claims				
Inpatient				
Outpatient				
Emergency Room				
Inpatient/Outpatient Other				
PRTF				
Specialized Child Svc Clinics				

Reporting Criteria:

General Specifications	Definition
Claim	Claim is defined as an original clean claim.
Claim Count	A claim count of one is applied to each claim. Therefore a claim that pays on the header and a claim that pays on the detail will both have a count of one.
Billing Provider Type	Billing Provider Type is designated with a state specific two (2) character field. Example: Billing Provider Type 01 = General Hospital

Provider Type Category	Billing Provider Type Category is a breakdown of a Billing Provider Type by specified criteria.
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
Total All Claims	Includes all Provider Types and Provider Type Categories included in the report.
'Provider Type'	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk.
'Provider Type Category'	Crosswalk of Provider Type Categories for General Hospital and Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Other non-Medicaid Provider Type	Category is used to report claims processed for Providers that do not have a Medicaid Provider ID or for Providers with a Provider Type that Medicaid does not recognize.

Claim Status	Column Label	Description
Received	Total Count	Total Count of all Original Claims received during the reporting period.
Received	Total Processed	Total Count of all Original Claims processed during the reporting period to a status of Pay, Deny or Suspended.
Received	Total Charges	Total charges for all received original claims. A claim that pays at the header should use the charges from the header. A claim that pays at the detail should include the charges from all the details.
Received	Avg. Charges	Calculated Field: 'Total Charges' from received status divided 'Total Count' from received status.
Pay	Total Count	Total Count of all Original Claims that adjudicated to a Pay status.
Pay	Percent	Calculated Field: 'Total Count' from pay status divided by 'Total Processed' from received status.
Pay	Total Charges	Total charges from original claims adjudicated to a pay status. Header paid claims will use the charges from the Header. Detail paid claims will use charge from the line items that have a pay status. Denied line item charges are not to be included in Total Charges.
Pay	Avg. Charges	Calculated Field: 'Total Charges' from pay status divided by 'Total Count' from pay status.
Pay	Total Paid	The total adjudicated claim paid amount by the MCO. Example: A claim adjudicated to pay $100. There is an outstanding A/R in financial for $200. The MCO should report the $100 adjudicated paid amount and not the $0 financial payment.
Pay	Avg. Paid	Calculated Field: 'Total Paid' from pay status divided by 'Total Count' from pay status.
Deny	Total Count	Total Count of all Original that adjudicated to a Deny status.
Deny	Percent	Calculated Field: 'Total Count' from deny status divided by 'Total Count' from received status.
Deny	Total Charges	Total charges for all denied original claims. A claim that pays at the header should use the charges from the header. A claim that pays at the detail should include the charges from all the details.
Deny	Avg. Charges	Calculated Field: 'Total Charges' from deny status divided by 'Total Count' from deny status.
Suspended	Total Count	Total Count of all Original Claims that moved to a suspended status. The claim shall be counted even if the claim later was changed to a Pay or Deny status during the reporting period.
Suspended	Percent	Calculated Field: 'Total Count' from suspended status divided by 'Total Count' from received status.
Suspended	Total Charges	Total charges for all suspended original claims. A claim that pays at the header should use the charges from the header. A claim that pays at the detail should include the charges from all the details.
Suspended	Avg. Charges	Calculated Field: 'Total Charges' from suspended status divided by 'Total Count' from suspended status.

Group:	Claims Processing	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, B
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provides the number of original clean claims processed during a reporting period reported by Billing Provider Type and claim status. There are four claim statuses to be included in the report:

Received;
Pay;
Deny; and
Suspended

Two (2) Billing Provider Types are further broken down as follows:

Billing Provider Type 01 General Hospital
Inpatient;
Outpatient;
Emergency Room; and
Inpatient/Outpatient Other

Billing Provider Type 54 Pharmacy
Pharmacy non-Behavioral Health Brand;
Pharmacy non-Behavioral Health Generic;
Pharmacy Behavioral Health Brand; and
Pharmacy Behavioral Health Generic

Sample Layout:

	Claims Received			
	Total Count	Total Processed	Total Charges	Avg. Charges
Total All Claims				
Inpatient				
Outpatient				
Emergency Room				
Inpatient/Outpatient Other				
Mental Hospital				
PRTF				
Specialized Child Svc Clinics				

	Adjudicated to Pay Status					
	Total Count	Percent	Total Charges	Avg. Charges	Total Paid	Avg. Paid
Total All Claims						
Inpatient						
Outpatient						
Emergency Room						
Inpatient/Outpatient Other						
Mental Hospital						
PRTF						
Specialized Child Svc Clinics						

	Adjudicated to Deny Status			
	Total Count	Percent	Total Charges	Avg. Charges
Total All Claims				

Inpatient				
Outpatient				
Emergency Room				
Inpatient/Outpatient Other				
Mental Hospital				
PRTF				
Specialized Child Svc Clinics				

	Placed in Suspended Status			
	Total Count	Percent	Total Charges	Avg. Charges
Total All Claims				
Inpatient				
Outpatient				
Emergency Room				
Inpatient/Outpatient Other				
Mental Hospital				
PRTF				
Specialized Child Svc Clinics				

Reporting Criteria:

General Specifications	Definition
Claim	Claim is defined as an original clean claim.
Claim Count	A claim count of one is applied to each claim. Therefore a claim that pays on the header and a claim that pays on the detail will both have a count of one.
Billing Provider Type	Billing Provider Type is designated with a state specific two (2) character field. Example: Billing Provider Type 01 = General Hospital
Provider Type Category	Billing Provider Type Category is a breakdown of a Billing Provider Type by specified criteria.
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
Total All Claims	Includes all Provider Types and Provider Type Categories included in the report.
'Provider Type'	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk.
'Provider Type Category'	Crosswalk of Provider Type Categories for General Hospital and Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Other non-Medicaid Provider Type	Category is used to report claims processed for Providers that do not have a Medicaid Provider ID or for Providers with a Provider Type that Medicaid does not recognize.

Claim Status	Column Label	Description
Received	Total Count	Total Count of all Original Claims received during the reporting period.
Received	Total Processed	Total Count of all Original Claims processed during the reporting period to a status of Pay, Deny or Suspended.
Received	Total Charges	Total charges for all received original claims. A claim that pays at the header should use the charges from the header. A claim that pays at the detail should include the charges from all the details.
Received	Avg. Charges	Calculated Field: 'Total Charges' from received status divided 'Total Count' from received status.

Pay	Total Count	Total Count of all Original Claims that adjudicated to a Pay status.
Pay	Percent	Calculated Field: 'Total Count' from pay status divided by 'Total Processed' from received status.
Pay	Total Charges	Total charges from original claims adjudicated to a pay status. Header paid claims will use the charges from the Header. Detail paid claims will use charge from the line items that have a pay status. Denied line item charges are not to be included in Total Charges.
Pay	Avg. Charges	Calculated Field: 'Total Charges' from pay status divided by 'Total Count' from pay status.
Pay	Total Paid	The total adjudicated claim paid amount by the MCO. Example: A claim adjudicated to pay $100. There is an outstanding A/R in financial for $200. The MCO should report the $100 adjudicated paid amount and not the $0 financial payment.

Pay	Avg. Paid	Calculated Field: 'Total Paid' from pay status divided by 'Total Count' from pay status.
Deny	Total Count	Total Count of all Original that adjudicated to a Deny status.
Deny	Percent	Calculated Field: 'Total Count' from deny status divided by 'Total Count' from received status.
Deny	Total Charges	Total charges for all denied original claims. A claim that pays at the header should use the charges from the header. A claim that pays at the detail should include the charges from all the details.
Deny	Avg. Charges	Calculated Field: 'Total Charges' from deny status divided by 'Total Count' from deny status.
Suspended	Total Count	Total Count of all Original Claims that moved to a suspended status. The claim shall be counted even if the claim later was changed to a Pay or Deny status during the reporting period.
Suspended	Percent	Calculated Field: 'Total Count' from suspended status divided by 'Total Count' from received status.
Suspended	Total Charges	Total charges for all suspended original claims. A claim that pays at the header should use the charges from the header. A claim that pays at the detail should include the charges from all the details.
Suspended	Avg. Charges	Calculated Field: 'Total Charges' from suspended status divided by 'Total Count' from suspended status.

Report#:	59	Created:	09/10/2011
Name:	Prior Authorizations	Last Revised:	7/1/2015
Group:	Medical Management	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, B
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report list the Prior Authorization (PA) activity during the reporting period. All PAs required by the MCO are to be listed regardless of the level of activity during the reporting period. If an MCO adds or deletes a PA from their program requirements then the MCO is to report that information when submitting the report.

Sample Layout:

Prior Authorization (PA)								
Provider Type/Category	Prior Authorizations Requested	Prior Authorizations Approved			Prior Authorizations Partial Approved			Prior Authorizations Denied
		Medical	Medical	Medical	Medical	Medical	Medical	
		Necessity (no MCO Service Limits)	Necessity and within MCO Service Limits	Necessity and Exceeded MCO Service Limits	Necessity (no MCO Service Limits)	Necessity and within MCO Service Limits	Necessity and Exceeded MCO Service Limits	
Inpatient								
Outpatient								
Emergency Room								

Inpatient/Outpatient Other								
Mental Hospital								
Other non-Medicaid Provider Type								
Total	0	0	0	0	0	0	0	0

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
'Provider Type'	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk.
'Provider Type Category'	Crosswalk of Provider Type Categories for General Hospital and Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Other non-Medicaid Provider Type	Category is used to report prior authorizations processed for Providers that do not have a Medicaid Provider ID or for Providers with a Provider Type that Medicaid does not recognize.
Total	Report the total of all PA activity listed in the report.

Column Label	Description
Prior Authorizations Requested	The total number of prior authorizations that were requested for each specific 'Provider Type/Category'. If no PA activity was requested for a specific 'Provider Type/Category' report 0.
Prior Authorizations Approved	The total number of prior authorizations that were approved for each specific "Provider Type/Category'. If no PA activity was requested for a specific 'Provider Type/Category' report 0.
PAs Approved: Medical Necessity (no MCO service Limits)	Prior authorizations required for medical necessity determination only. There are no MCO service limits for the service being prior authorized and the MCO approved all of the units requested.
PAs Approved: Medical Necessity and within MCO Service Limits	The MCO has service limits and a medical necessity determination for the service that is being prior authorized. Only report the prior authorizations if the MCO approved all of the units requested and the units approved did not exceed MCO service limits.

PAs Approved: Medical Necessity and Exceeded MCO Service Limits	The MCO has service limits and a medical necessity determination for the service that is being prior authorized. Only report the prior authorizations if the MCO approved all of the units requested and the total units approved
Prior Authorizations Partially Approved	The total number of prior authorizations that were partially approved for each specific "Provider Type/Category'. If no PA activity was requested for a specific 'Provider Type/Category' report 0.
PAs Partially Approved: Medical Necessity (no MCO service Limits)	Prior authorizations required for medical necessity determination only. There are no MCO service limits for the service being prior authorized and the MCO approved some but not all of the units requested.
PAs Partially Approved: Medical Necessity and within MCO Service Limits	The MCO has service limits and a medical necessity determination for the service that is being prior authorized. Only report the prior authorizations if the MCO approved some but not all of the units requested and the units approved did not exceed MCO service limits.
PAs Partially Approved: Medical Necessity and Exceeded MCO Service Limits	The MCO has service limits and a medical necessity determination for the service that is being prior authorized. Only report the prior authorizations if the MCO approved some but not all of the units requested and the total units approved exceeded the MCO service limits.
Prior Authorizations Denied	The total number of prior authorizations that were denied for each specific "Provider Type/Category'. If no PA activity was requested for a specific 'Provider Type/Category' report 0.

Report #:	60	Created:	08/20/2011
Name:	Original Claims Payment Activity	Last Revised:	02/27/2015
Group:	Claims Processing	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, B
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provides the number of original clean claims paid during a reporting period and length of time from receipt of a clean original claim to claim payment; the number of original clean claims denied during a reporting period and length of time from receipt of a clean original claim to claim denial; the number of original clean claims in a suspended status during a reporting period and length of time from receipt of an original claim.

Sample Layout:

	Claim Activity				
	1-30 Days	31-60 Days	61-90 Days	91+ Days	Total Claims
Total All Claims Paid					
Total All Claims Denied					
Total All Claims Suspended					

Reporting Criteria:

General Specifications	Definition
Claim	Claim is defined as an original clean claim that has been paid/denied/suspended.
Claim Count	A claim count of one is applied to each paid/denied/suspended claim. Therefore a header paid claim that is paid/denied/suspended and a detailed paid claim that is paid/denied/suspended on all details will both have a count of one.
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
Total All Claims Paid	Includes all clean claims that have been paid in the reporting period
Total All Claims Denied	Includes all clean claims that have been denied in the reporting period
Total All Claims Suspended	Includes all clean claims that have been suspended in the reporting period

Column Label	Description
1-30 Days	Total count of all claims paid/denied/suspended during the reporting period for which the claim was in process for 1 to 30 calendar days from receipt of a clean claim.
31-60 Days	Total count of all claims paid/denied/suspended during the reporting period for which the claim was in process for 31 to 60 calendar days from receipt of a clean claim.
61-90 Days	Total count of all claims paid/denied/suspended during the reporting period for which the claim was in process for 61 to 90 calendar days from receipt of a clean claim.
91+ Days	Total count of all claims paid/denied/suspended during the reporting period for which the claim was in process for 91 or more calendar days from receipt of a clean claim.
Total Claims	Total count of all claims paid/denied/suspended during the reporting period.

Report#:	64	Created:	10/01/2016
Name:	Monthly Benefit Payments	Last Revised:	
Group:	Financial	Report Status:	Active
Frequency:	Monthly	Exhibits:	D, E, F
Period:	First day of month through the last day of the month.		
Due Date:	15th of the month following the reporting period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Monthly Benefit Payments report provides MCO financial activity for the Medicaid expansion population, Kentucky Children's Health Insurance Program (KCHIP), and all other Medicaid populations by Month and State Category of Service. Report only includes financial activity related to Benefits including claims, claim adjustments, mass adjustments, sub-capitation, and other financial payments/recoupment activity not processed as part of claims activity. Categories of Service are grouped by Medicaid Mandatory and Medicaid Optional Services. Criteria to properly identify and report EPSDT services and KCHIP services are to be applied as outlined below.

Sample Layout:

COS	COS Description	Expansion Medicaid	KCHIP	Other Medicaid	Total
Medicaid Mandatory Services					
02	Inpatient Hospital				
12	Outpatient Hospital				
	Subtotal: Mandatory Services				
03	Mental Hospital				
04	Renal Dialysis				
	Subtotal: Optional Services				
	Total: Mandatory and Optional Services				
	Reinsurance				
	Pharmacy Rebates				
	Grand Total				

Reporting Criteria:

General Specifications	Definition
Financial Activity	Payments reported are to be based on date of payment.
EPSDT Services	Multiple Provider Types may provide EPSDT services. Reference Exhibit E for EPSDT Category of Service crosswalk for additional information regarding the identification of EPSDT services.
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Subtotal: Mandatory Services	Calculated Field: Total for all mandatory category of services listed in the report.
Subtotal: Optional Services	Calculated Field: Total for all optional category of services listed in the report.
Total: Mandatory and Optional Services	Calculated Field: Total of 'Subtotal: Mandatory Services' and 'Subtotal: Optional Services'.
Reinsurance	MCO premium payments for stop-loss insurance coverage.
Pharmacy Rebates	Drug Rebates collected by the MCO. 'Pharmacy Rebates' is to be reported as a negative value. Note: The state is responsible for collecting federal drug rebates.
Grand Total	Calculated Field: Total of 'Total: Mandatory and Optional Services', 'Reinsurance' and 'Pharmacy Rebates'.

Column Label	Description
COS	Category of Service: A two digit, State specific identification of services primarily identified by use of Provider Type. Reference Exhibit D for Category of Service crosswalk.
COS Description	Description for 'COS'
Expansion Medicaid	The Expansion Medicaid population services are to be reported separately from the KCHIP population services. Population to be those members who qualified based on criteria set forth in the Affordable Care Act (ACA). Reference Exhibit F for the Medicaid Eligibility Group crosswalk.
KCHIP	The Kentucky Children's Health Insurance Program (KCHIP) population services are to be reported separately from the Medicaid population services. Populations to be included are based on the Medicaid Eligibility Groups (MEGs):
	1. MCHIP 2. SCHIP Reference Exhibit F for the Medicaid Eligibility Group crosswalk.
Other Medicaid	All Medicaid members not reported in the previous two groups.

[redacted]

Report#:	65	Created:	02/13/2012
Name:	Foster Care	Last Revised:	07/25/2015
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services Kentucky Department for Community Based Services		

Description: Quarterly report provides information on the Foster Care population for each MCO and broken down by Region.

Sample Layout:

MCO Region	Foster Care Region	Number of New Foster Care Members	Number of Existing Foster Care Members	Number of New Foster Care Members Enrolled into CM	Number of Existing Foster Care Members Enrolled into CM	Number of New Foster Care Members Enrolled into DM	Number of Existing Foster Care Members Enrolled into DM	Number of New Foster Care Members with Completed HRAs	Number of Existing Foster Care Members with Completed HRAs

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in order: MCO Region

Row Label	Description
NA	NA

Column Label	Description
MCO Region	Provide the member's MCO region.
Foster Care Region	Provide the member's Foster Care region.
Number of New Foster Care Members	Provide the total number of new Foster Care Members during the month.
Number of Existing Foster Care Members	Provide the total number of existing Foster Care Members during the month.
Number of New Foster Care Members Enrolled into Case Management	Provide the total number of new Foster Care Members enrolled into Case Management during the month.
Number of Existing Foster Care Members Enrolled into Case Management	Provide the total number of existing Foster Care Members enrolled into Case Management during the month.

Number of New Foster Care Member Enrolled into Disease Management	Provide the total number of new Foster Care Members enrolled into Disease Management during the month.
Provide the total number of Existing Foster Care Members enrolled into Disease Management	Provide the total number of existing Foster Care Members enrolled into Disease Management during the month.
Number of New Foster Care Members with Completed HRAs	Provide the total number of new Foster Care Members with completed HRAs during the month.
Number of Existing Foster Care Members with Completed HRAs	Provide the total number of existing Foster Care Members enrolled into HRAs during the month.

Report#:	66	Created:	02/10/2012
Name:	Guardianship	Last Revised:	07/15/2015
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services Kentucky Department for Aging and Independent Living		

Description: Quarterly report provides information on the Guardianship population for each MCO and broken down by Region.

Sample Layout:

MCO Region	Guardianship Region	Number of New Guardianship Members	Number of Existing Guardianship Members	Number of New Guardianship Members Enrolled into CM	Number of Existing Guardianship Members Enrolled into CM	Number of New Guardianship Members Enrolled into DM	Number of Existing Guardianship Members Enrolled into DM	Number of New Guardianship Members with Completed HRAs	Number of Existing Guardianship Members with Completed HRAs

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in order: MCO Region

Row Label	Description
NA	

Column Label	Description
MCO Region	Provide the member's MCO region.
Guardianship Region	Provide the member's Guardianship region.
Number of Guardianship Members	Provide the total number of new Guardianship Members during the month.
Number of Existing Guardianship Members	Provide the total number of existing Guardianship Members during the month.
Number of New Guardianship Members Enrolled into Case Management	Provide the total number of new Guardianship Members enrolled into Case Management during the month.
Number of Existing Guardianship Members Enrolled into Case Management	Provide the total number of existing Guardianship Members enrolled into Case Management during the month.
Number of New Guardianship Member Enrolled into Disease Management	Provide the total number of new Guardianship Members enrolled into Disease Management during the month.
Provide the total number of Existing Guardianship Members enrolled into Disease Management	Provide the total number of existing Guardianship Members enrolled into Disease Management during the month.
Number of New Guardianship Members with Completed HRAs	Provide the total number of new Guardianship Members with completed HRAs during the month.
Number of Existing Guardianship Members with Completed HRAs	Provide the total number of existing Guardianship Members enrolled into HRAs during the month.

Report#:	68	Created:	08/21/2011
Name:	Additions to Provider Network	Last Revised:	10/01/2011
Group:	Provider Enrollment	Report Status:	Active
Frequency:	Monthly	Exhibits:	C
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Report documents additions to the MCO Provider Network

Sample Layout:

NPI	Medicaid ID	Last/Entity Name	First Name	Phone	Address 1	Address 2	City	State	Zip	County Name	Specialty

Reporting Criteria:

Terminology	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Column Label	Description
NPI	The Provider's NPI
Medicaid ID	The Provider's Medicaid Identification Number
Last/Entity Name	For an individual Medical Provider report the last name of the Provider; When the addition applies to a Provider group report the group name; When the addition applies to a subcontractor report the last name of the company contact.
First Name	The Provider's first name
Phone	Provide the contact number for the 'Last/Entity Name' listed.
Address 1	First line of the mailing address for the 'Last/Entity Name' listed.
Address 2	Second line of the mailing address for the 'Last/Entity Name' listed.
City	City of the mailing address for the 'Last/Entity Name' listed.
State	A two character designation for the state of the mailing address for the 'Last/Entity Name' listed.
Zip	Five character zip code of the mailing address for the 'Last/Entity Name' listed.
County Name	The complete name of the county where the provider is located. (County name is not necessary if the provider is located out of Kentucky)
Specialty	The medical specialty of the 'Last/Entity Name' listed. (Do not use abbreviations)

Report#:	69	Created:	08/21/2011
Name:	Termination from MCO Activity	Last Revised:	02/16/2015
Group:	Provider Enrollment	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description: Report documents terminations to the MCO Provider Network

Sample Layout:

NPI	Medicaid ID	Last/Entity Name	First Name	Phone	Address 1	Address 2	City	State	Zip	County Name	Specialty	Reason

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
NA	NA

Column Label	Description
NPI	The Provider's NPI
Medicaid ID	The Provider's Medicaid Identification Number
Last/Entity Name	For an individual Medical Provider report the last name of the Provider; When the termination applies to a Provider group report the group name; When the termination applies to a subcontractor report the last name of the company contact.
First Name	The Provider's first name
Phone	Provide the contact number for the 'Last/Entity Name' listed.
Address 1	First line of the mailing address for the 'Last/Entity Name' listed.
Address 2	Second line of the mailing address for the 'Last/Entity Name' listed.
City	City of the mailing address for the 'Last/Entity Name' listed.
State	A two character designation for the state of the mailing address for the 'Last/Entity Name' listed.
Zip	Five character zip code of the mailing address for the 'Last/Entity Name' listed.
County Name	The complete name of the county where the provider is located. (County name is not necessary if the provider is located out of Kentucky)
Specialty	The medical specialty of the 'Last/Entity Name' listed. (Do not use abbreviations)

Reason	The reason for suspension or termination given by the MCO. Combines the Reason Code and Reason Code Description. Format: 'Reason Code'<space>'-'<space>'Reason Code Description' List of values for suspension or termination are provided in Exhibit C: Provider Enrollment Activity Reasons.

Report #:	70	Created:	08/21/2011
Name:	Denial of MCO Participation	Last Revised:	09/24/2011
Group:	Provider Enrollment	Report Status:	Active
Frequency:	Monthly	Exhibits:	C
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Report documents any Provider of Subcontractor who is denied participation with the MCO. Only those Providers or Subcontractors who are not currently participating with the MCO are to be reported.

Sample Layout:

Providers or Subcontractors Denied Participation with the MCO												
NPI	Last/Entity Name	First Name	Title	Phone	Addr. 1	Addr. 2	City	State	Zip	County	Co. Name	Reason

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
NA	NA

Column Label	Description
NPI	NPI should be reported as a text string. When the denial applies to a Medical Provider report the Provider's NPI. When the denial is for a subcontractor report 'Subcon'.
Last/Entity Name	When the denial applies to an individual Medical Provider report the last name of the Provider. When the denial applies to a Provider group report the group name. When the denial applies to a subcontractor report the last name of the company contact.
First Name	When the denial applies to an individual Medical Provider report the first name of the Provider. When the denial applies to a Provider group report the group name. When the denial applies to a subcontractor report the first name of the company contact.
Title	When the denial applies to an individual Medical Provider report the title of the Provider. When the denial applies to a Provider Group report 'NA'. When the denial applies to a subcontractor report the title of the company contact.
Phone	Provide the contact number for the 'Last/Entity Name' listed.
Addr. 1	First line of the mailing address for the 'Last/Entity Name' listed.
Addr. 2	Second line of the mailing address for the 'Last/Entity Name' listed.
City	City of the mailing address for the 'Last/Entity Name' listed.
State	A two character designation for the state of the mailing address for the 'Last/Entity Name' listed.
Zip	Five character zip code of the mailing address for the 'Last/Entity Name' listed.
County	A three character code for the county of the mailing address for the 'Last/Entity Name' listed.
Co. Name	The name of the county of the mailing address for the 'Last/Entity Name' listed.
Reason	The reason for denial given by the MCO. Combines the Reason Code and Reason Code Description. Format: 'Reason Code'<space>'-'<space>'Reason Code Description' List of values for denial are provided in Exhibit C: Provider Enrollment Activity Reasons.

Report #:	71	Created:	09/01/2011
Name:	Provider Outstanding Account Receivables	Last Revised:	09/26/2011
Group:	Finance and Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Provider Outstanding Account Receivables report contains all accounts receivable that have reached 180 days or older in age. If there are no accounts receivable 180 days or older as of the last day of the reporting period then the report is to be submitted with the 'Total' values set to $0.00 and the following comment located at the bottom of the report:

'NO ACCOUNTS RECEIVABLE 180 DAYS OR OLDER TO REPORT AS OF THE END OF THE REPORTING PERIOD'

Sample Layout:

Outstanding Account Receivables 180 Days or Older

	Provider Tax	Medicaid Provid	Provid	Provider Nam	AR Set up Dat	AR	AR Setup Reas	AR Setup Amo	Revised AR Setup Amou		AR	Write Off Indica	TPL

AR ID	ID/SSN	er ID	er NPI	e	e	Ag	on	unt	nt	Disposit	Balan	tor	Indic
Total								$0.00	$0.00	$0.00	$0.00		

NO ACCOUNTS RECEIVABLE 180 DAYS OR OLDER TO REPORT AS OF THE END OF THE REPORTING PERIOD

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by provider name.

Row Label	Description
Total	Calculated Field: Total of all reported in each column for 'AR Setup Amount', 'Revised AR Setup Amount', 'Disposition' and 'AR Balance'.

Column Label	Description
AR ID	The MCO identifier for the account receivable.
Provider Tax ID/SSN	Billing Provider Federal Tax ID (FEIN) or SSN of the Billing Provider.
Medicaid Provider ID	The Provider's Medicaid ID
Provider NPI	The Provider's NPI number as reported on the claim.
Provider Name	Concatenate the Provider's 'Last Name', 'First Name' 'Middle Initial'.
AR Setup Date	The date the account receivable was established.
AR Age	The age measured in days of the account receivable as of the last day of the reporting period. The setup date for the account receivable is to be counted.
AR Setup Reason	The reason behind the creation of the account receivable.
AR Setup Amount	The amount originally requested from the provider.
Revised AR Setup Amount	When MCO procedures allow modification of the original account receivable setup amount due to a dispute resolution or write off report the new account receivable setup amount. If the account receivable balance is adjusted rather than the setup amount report the original account receivable setup amount.
Disposition	The total amount applied to the account receivable during the reporting period. Dispositions may include payments received, recoupment or adjustments (dispute resolution or write offs).
AR Balance	The balance of the account receivable as of the last day of the reporting period.
Write Off Indicator	Indicates if the account receivable was partially or completely written off. Valid values are: N = Account receivable not written off. C = Account receivable completely written off. P = Account receivable partially written off.
TPL Indicator	Indicates if the account receivable resulted from identification of TPL. Valid values are 'Y' or 'N'.

Report #:	72	Created:	09/07/2011

Name:	Member Violation Letters and Collections	Last Revised:	09/25/2011
Group:	Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report lists the complaints received and actions taken regarding potential Medicaid program violations by a Member. The MCO is to open a case for each complaint received and document the related activity for all active/open cases during the reporting period.

A copy of each Medicaid Program Violation (MPV) letter with signature that is mailed during the reporting period is to be provided as an attachment when the Member Violation Letters and Collections report is submitted.

Sample Layout:

Medicaid Program Violation Letters and Collections												
Case	Case	Member	Member	Member	Date Complaint	Source of	Summary of	Date Case	Actions	Overpayment Amount	Overpayment Collected	Total Overpayment Collected

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted as follows: First sort order by 'Case Status' (N, A, C, I). Second sort order by ascending 'Date Case Opened'.

Row Label	Description
NA	NA

Column Label	Description
Case Status	Identifies if the case is New, Existing or Closed. Valid values are: N = New Case opened during reporting period. A = Active Case and status update C = Closed case with disposition I = Inactive case and status description Only one Case Status is to be reported per line. If a Case is Opened and Closed during the same reporting period then one record with Case Status = N and one record with a Case Status = C will be reported for the case.
Case ID	The Case unique identifier assigned by the MCO.
Member Name	The name of the member the complaint is against. Concatenate the Member's <Last Name>, <First Name> <Middle Initial>.
Member Medicaid ID	The Member's Medicaid ID.
Member MCO ID	The Member's MCO ID.
Date Complaint Received	The date the complaint was received by the MCO.
Source of Complaint	Where the complaint was received from (e.g. hotline).
Summary of Complaint	Short description of the complaint.
Date Case Opened	Date case was opened for review by the MCO. A case shall be opened for all complaints received.
Actions Taken	Activity that occurred after case opened. Valid values are: 1. IO = Investigation Opened 2. ICNA = Investigation closed with no further action with disposition description 3. MPV = Medicaid Program Violation Letter Sent 4. MPV-NR = Member has not responded to MPV Letter 5. MPV-PS = Member has responded and set up payment schedule/plan 6. MPV-F = Member has paid in full More than one value may be reported per record.
Overpayment Amount	Amount of overpayment identified during the investigation.
Overpayment Collected	Amount of overpayment collected during the reporting period.
Total Overpayment Collected	The total amount of the overpayment collected through the end of the reporting period. Includes previous reporting period collections.

Report#:	73	Created:	09/07/2011
Name:	Explanation of Member Benefits, (EOMB)	Last Revised:	10/17/2011
Group:	Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of the month through the last day of the month		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report identifies the MCO activity in verifying Member benefits for which the MCO received, processed and paid a claim in accordance with 42 CFR 455.20. A minimum of 500 claims is to be sampled for purpose of complying with 42 CFR 455.20. An EOMB is to be mailed within 45 days of payment of claims.

Sample Layout:

Meets 42 CFR 455.20	Member Region	Billing Provider Type	MCO ICN	Date of Contact	Member Name	Member Medicaid ID	Date of Service	Service Code	Service Code Description
Total (Y)									
Total									
(N)									

Meets 42 CFR 455.20	Member Region	Billing Provider Type	MCO ICN	Payer	Billing Provider Name	Billing Provider Medicaid Number	Rendering Provider Name	Rendering Provider Medicaid Number	Billed Amount	Paid Amount	Response	Action
Total (Y)												
Total (N)												

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by number in column A.

Row Label	Description
Total (Y)	Total (Y) for MCO ICN: Report the unduplicated count of 'MCO ICN' for which the 'Meets 42 CFR 455.20' indicator was set to 'Y'. Total (Y) for Billed Amount: Report the sum of all 'Billed Amount' for which the 'Meets 42 CFR 455.20' indicator was set to 'Y'. Total (Y) for Paid Amount: Report the sum of all 'Paid Amount' for which the 'Meets 42 CFR 455.20' indicator was set to 'Y'. Total (Y) for Collections: Report the sum of all 'Collections' for which the 'Meets 42 CFR 455.20' indicator was set to 'Y'.
Total (N)	Total (N) for MCO ICN: Report the unduplicated count of 'MCO ICN' for which the 'Meets 42 CFR 455.20' indicator was set to 'N'. Total (N) for Billed Amount: Report the sum of all 'Billed Amount' for which the 'Meets 42 CFR 455.20' indicator was set to 'N'. Total (N) for Paid Amount: Report the sum of all 'Paid Amount' for which the 'Meets 42 CFR 455.20' indicator was set to 'N'. Total (N) for Collections: Report the sum of all 'Collections' for which the 'Meets 42 CFR 455.20' indicator was set to 'N'.

Column Label	Description
Meets 42 CFR 455.20	Yes or No indicator to be set as follows: 'Y' is to be used for all letters that were sent in order to meet the federal requirements of 42 CFR 455.20. 'N' is to be used for all letters that were sent for purposes other than compliance with 42 CFR 455.20.

Member Region	The MCO Region where the Member resides. Reported as a two (2) character text string. Valid values are 01, 02, 03, 04, 05, 06, 07 and 08.
Billing Provider Type	Billing Provider Type is designated with a state specific two (2) character field. Example: Billing Provider Type 01 = General Hospital
MCO ICN	The MCO Internal Control Number used to identify the claim. To be reported as a text string.
Date of Contact	The date the MCO imitated the action. Letter = Date of the Letter
Contact Type	The type of communication the MCO used to contact the Member. Valid Codes are: L = Letter
Member Name	The name of the member that received the EOB letter.
Member Medicaid ID	The Medicaid ID of the Member contacted. To be reported as a text string.
Date of Service	Date of Service of claim
Service Code	The code (e.g. procedure code, revenue code) for the service that was rendered to the member.
Service Code Description	The description of the 'Service Code' for the service that was rendered to the member.
Payer	The name of the payer source. If the MCO paid the claim report MCO. If an MCO subcontractor paid the claim then list the service description of the Subcontractor (i.e. Pharmacy, Dental, Vision, PCP Cap)
Billing Provider Name	The name of the provider who has billed for service rendered.
Billing Provider Medicaid Number	The Medicaid ID number for the provider who has billed for service rendered.
Rendering Provider Name	The name of the provider who rendered the service to the member for that specific date of service.
Rendering Provider Medicaid Number	The Medicaid ID number for the provider who has rendered the service to the member.
Billed Amount	Total billed amount for the 'Service Code'.
Paid Amount	Total paid amount by the MCO or the MCO subcontractor for the 'Service code'.
Response	If the Member has not responded then report 'No Member Response'. If the Member responded then concatenate the following: <date of response>,<->,<validation code>. Validation codes are: RB = Received Benefit NB = No Benefit Received PB = Partial Benefit Received
Action	The Action the MCO took based on the Member's response. Multiple actions may be reported. Valid Actions are: NAT: No Action Taken IPI: Initiated Provider Investigation RPA: Requested Provider Billing Adjustment ARS: Accounts Receivable Setup to Recoup Payment

Report #:	74(A)	Created:	10/19/2011
Name:	Medicaid Program Lock-In Reports/Admits Savings Summary Table	Last Revised:	05/14/2019
Group:	Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report lists the monthly savings for the total number of members admitted during the month and sub-categorized by the billing provider type codes.

Sample Layout:

Billing Provider Type Codes	Paid Amount		Savings YTD	Monthly Admits	Average Savings YTD
	1 Year Pre Lock-In	1 Month Post Lock-In			
Totals					

General Specifications	**Definition**
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Row Label	**Description**
Provider Type Codes	Provider type codes
Totals	The total sum of combined provider type codes in dollar amount

Reporting Criteria:

Column Label	**Description**
Billing Provider Type Codes	Listed are the different provider type codes to be utilized for this report.
Paid Amount	The paid amount is divided into two categories; (1) 1 Year Pre-LIP is the total paid amount for each provider type listed in the first column (Billing provider type codes) for the total number of members admitted one year prior to being assigned to the Lock-In Program ; (2) Is the monthly running YTD (year to date)of paid amounts for each provider type listed in the first column for the member after being assigned into the Lock-In Program for the first year from the MCO taking over the LIP. After the first 12 months, the second category will report the 1st year post – LIP for each report month and yearly thereafter.(Example: column (2) will initially read 1 month post LI, then the next month it will read 2 month post …through the first 12 months. After the first year, the second category will always list **1 year Post-LIP** for the month the report is generated.

Savings YTD	The total savings YTD for each provider type for the reporting period.
Monthly Admits	The total number of members that were placed into the Lock-In Program for the monthly reporting period.
Average Saving YTD	The average saving YTD (year to date) per member per month per provider type.(Savings YTD : Monthly admits = average savings YTD)

Report #:	74(B)	Created:	10/19/2011
Name:	Medicaid Program Lock-In Reports/Rolling Annual Calendar Comparison	Last Revised:	05/14/2019
Group:	Program Integrity	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report lists the total savings created by the Lock-In Program reported on a quarterly basis.

Sample Layout:

Billing Provider Type Codes	**Savings for 201? YTD**				**Total savings 201? YTD**	**Savings for 201? YTD**				**Total Savings 201? and 201? YTD**	**Notes/ Comments**
	1st Quarter	**2nd Quarter**	**3rd Quarter**	**4th Quarter**		**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**		
TOTALS:											

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Row Label	**Description**
Billing Provider Type Codes	Billing Provider type codes
Totals	The total sum of combined billing provider type codes in dollar amount

Column Label	Description
Billing Provider Type Codes	Billing Provider type codes
Savings for YTD (201?)	Savings for year to date totals
1st, 2nd, 3rd, and 4th quarters for year reported (201?)	The total savings for each provider type listed per calendar quarter of year reported.
Total Savings 201? YTD	The sum of the total savings for each provider type listed of year reported
Savings for YTD (201?)	Savings for year to date totals per quarter
1st, 2nd, 3rd, and 4th quarters for year reported (201?)	The total savings for each provider type listed per calendar quarter of year reported.
Total Savings 201? YTD	The sum of the total savings for each provider type listed of year reported
Notes/Comments	Additional Notes/Comments

Report #:	74(C)	Created:	10/19/2011
Name:	Medicaid Program Lock-In Reports/Member Initial Lock-In Effective Dates	Last Revised:	05/14/2019
Group:	Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report lists the total number of members that have been admitted and discharged into the Lock-In Program for the month reported. The report also lists the total number of currently active member assigned to the Lock-In Program.

Sample Layout:

Monthly	Number of Members **Admitted** per Month	Number of Members **Discharged** per Month	Total Number of Members **Active** in LIP per Month	Notes/Comments
Total YTD				

Reporting Criteria:

General Specifications	**Definition**
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Row Label	**Description**
Year	The year listed for the reporting period.
Month	The individual month listed for the year for the reporting period.

Column Label	**Description**
Monthly Data	List the individual month for each reporting year.
Member	Member count of admitted/discharged/active members.
Number of Members **Admitted** per Month	The total number of members that have been admitted into the Lock-In Program during the monthly reporting period.
Number of Members **Discharged** per Month	The total number of members that have been discharged from the Lock-In Program during the monthly reporting period.
Total Number of Members **Active** in LIP per Month	The total number of members that are active or currently assigned to the Lock-In Program during the monthly reporting period.
Notes/Comments	Additional notes/comments

Report#:	75	Created:	09/01/2011
Name:	SUR Algorithms	Last Revised:	09/22/2011
Group:	Program Integrity		Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The SUR Algorithm report identifies potential overpayments to providers determined to be erroneous, abusive or otherwise inconsistent with DMS and/or MCO policy. The report is to include only those providers for which a demand letter was sent.

MCO algorithms that are routinely run are to be identified, documented and provided to DMS prior to the first submission of the SUR Algorithms Report. If the MCO modifies and/or creates specially designed algorithms that are used in reporting any subsequent SUR Algorithm report, the MCO is to provide DMS at the time of report submission documentation related to the algorithm including the algorithm name, algorithm description and algorithm logic.

Sample Layout:

Program Integrity - SUR - Algorithms											
Medicaid Provider ID	Provider Name	Tax ID/SSN	Provider Type	Algorithm Name	Demand LTR Date	Review Period	Identified Overpayment	Disputed	Revised Overpayment	Collected Overpayment	Total Overpayment Collected
				sub-total for <Algorithm Name>:			$0.00	0	$0.00	$0.00	$0.00
				sub-total for <Algorithm Name>:			$0.00	0	$0.00	$0.00	$0.00
				sub-total for <Algorithm Name>:			$0.00	0	$0.00	$0.00	$0.00
				Total for all Algorithms:			$0.00	0	$0.00	$0.00	$0.00

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'Algorithm Name' by 'Demand LTR Date' by 'Medicaid Provider ID'.

Row Label	Description
Sub-total for <Algorithm Name>:	A sub-total for the 'Identified Overpayment', 'Revised Overpayment', 'Collected Overpayment' and 'Total Overpayment Collected' columns for each 'Algorithm Name' is to be calculated for all reported activity. A sub-total of all <Y> listed in the 'Disputed' column is to be calculated for all reported activity.
Total for all Algorithms:	A total of all algorithm sub-totals is to be calculated for the 'Identified Overpayment', 'Revised Overpayment', 'Collected Overpayment' and 'Total Overpayment Collected' columns for all reported activity. A total of all algorithms sub-totals is to be calculated for the "Disputed' column for all reported activity.

Column Label	Description
Medicaid Provider ID	The Provider's Medicaid ID
Provider Name	Concatenate the Providers <Last Name>, <First Name>, Middle Initial>
Tax ID/SSN	The Provider's FEIN number or SSN
Provider Type	Concatenate <Billing Provider Type> - <Billing Provider Type Description>. Values for Provider Type are provided in Exhibit A: Billing Provider Type and Specialty Crosswalk.
Algorithm Name	The name and/or title designated to a specific algorithm.
Demand LTR Date	The letter and mailing date of the demand letter pertaining to a specific algorithm and Provider.
Review Period	The time span (dates-of-service) of claims reviewed for a specific algorithm.

Identified Overpayment	A potential overpayment amount identified through an algorithm as reported on the demand letter.
Disputed	Valid codes are: Y = Demand Letter was Disputed N= Demand Letter was not Disputed
Revised Overpayment	If the Demand Letter was disputed and the overpayment amount was changed then report the new overpayment amount. Otherwise report the overpayment amount as identified in the Demand Letter.
Collected Overpayment	The amount collected during the reporting period based on a specific algorithm demand letter.
Total Overpayment Collected	The total amount collected since the demand letter was sent through the end of the reporting period.

Report #:	76	Created:	09/01/2011
Name:	Provider Fraud Waste and Abuse Report	Last Revised:	4/9/19
Group:	Program Integrity	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Provider Fraud Waste and Abuse report should contain all cases that are in the initial (not reported on the TIPS report) investigation stages acted upon during the reporting period. New cases, existing case actions, and closed cases within the reporting period are to be identified and the outcome of the investigation documented based upon the most current DMS State Requirements regarding Detecting and Preventing Fraud, Waste and Abuse .

Sample Layout:

Provider Fraud Waste and Abuse-Active Cases																
PIU Case Number	Provider Name	Medicaid Provider ID	Provider NPI	Source of Complaint	OIG Case Number (if applicable)	Date Complaint or Referral Received	Date Case Opened	MAT Case (Y/N)	Summary of Complaint (with timeframe reviewed)	Initial Investigation (Y/N)	PIU Action(s) Taken and Date(s)	Referred to DMS (Y, N, E, NA-Reason)	Date Referred to DMS	Provider on Prepayment (Y/N) (Date if applicable)	Overpayment Identified	Date Case Closed (with Code)

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'Medicaid Provider ID'

Row Label	Description
NA	NA

Column Label	Description
PIU Case Number	The unique number assigned by the MCO to identify the case.
Provider Name	The specific name of the provider (individual, group or clinic) that the complaint was filed against.
Medicaid Provider ID	Report the Medicaid Provider ID if an individual provider. Report the Medicaid Billing Provider ID if a Facility or group practice. ID is to be reported as a text string.
Provider NPI	The Provider's NPI number reported as a text string.

Source of Complaint	Valid codes are to reported using the list below. Please note there may be multiple referral sources. Code — Code Description DMS — The Department for Medicaid Services OIG — The Office of Inspector General INT — MCO internal source such as hotline, algorithm, SIU, etc. The Internal source should be specified OTH — MCO other source. Source should be identified
OIG Case Number	The number assigned to the case by OIG or N/A (Applicable only to OIG Source of Complaint).If the source of complaint is OIG, an OIG Case # is required in the OIG Case Number column.
Date Complaint or Referral Received	The date the complaint or referral was received by the MCO.
Date Case Opened	Date the case was opened for review by the MCO.
MAT (Y or N)	Case involves Medication Assisted Treatment (Y- yes, N-no).
Summary of Complaint with timeframe reviewed	Short description of the complaint and MCO insight regarding pertinent facts to case. The timeframe under review should be included.
Initial Investigation (Y or N)	Initial Investigation (Y- yes, N-no). (The case has been opened and is being actively worked. If a case has been referred to DMS or submitted for closure it would not be in the initial investigation stage.)
PIU Action(s) Taken and Date(s)	Brief description of tangible action(s) taken during the reporting period with corresponding date(s). If no action was taken, explain why.
Referred to DMS (Y, N , E or N/A-Reason)	Investigative report was referred to DMS with MCO recommendation and the MCO requesting permission to take action. Code — Code Description Y — Yes, case referred to DMS. N — No, case has not been referred to DMS. E — Extension Requested N/A-Reason — Referral to DMS not applicable. The reason should be specified if the case was closed (not substantiated).
Date Referred to DMS	The date the action in the previous column was taken (N/A would only be applicable for No and N/A in previous column).
Provider on Prepayment (Y/N) (Date if applicable)	Provider on Prepayment(Y- yes, N-no). If applicable, include the date the provider was placed on prepayment.
Overpayment Identified	Amount identified during the investigation that may have resulted from fraud, waste and/or abuse. Please note any investigation involving any overpayment over the $500 threshold must be referred to DMS prior to MCO action.

Date Case Closed (with Code)	The Date the Case was closed or N/A. Please note if your MCO has referred the case to DMS **based upon a reasonable belief that fraud, waste or abuse has occurred** and if your MCO is not making tangible case updates every thirty (30) business days to the case the investigation should show as closed for purposes of the report and a notation made in the MCO case file. The code for these cases are as follows based upon the decision of DMS after submission of the MCO Standardized Investigative Report:

Code	Code Description
ICNA	Investigation Closed (no Action) with permission from DMS.
AC	Administrative Action Taken by MCO (no Fraud) with permission from DMS.
OIG	Acknowledgement from DMS case was referred for Preliminary Investigation.

Report#:	77	Created:	10/02/2011
Name:	Member Fraud Waste and Abuse	Last Revised:	4/9/19
Group:	Program Integrity	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Member Fraud Waste and Abuse report should contain all cases acted upon during the reporting period. New cases, action taken on existing cases, and closed cases are to be identified and the outcome of the investigation documented.

Sample Layout:

Member Fraud Waste and Abuse														
PIU Case Number	Medicaid Member ID	Member Name	Date Complaint or Referral Received	Source of Complaint	OIG Case Number (if applicable)	MAT Related (Y or No)	Date Case Opened	Summary of Complaint with timeframe reviewed	PIU Action(s) Taken with Date(s)	Initial Investigation (Y or N)	Overpayment Identified	Referred to DMS (Y, N, E or N/A-Reason)	Date Referred to DMS	Date Case Closed

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'Medicaid Member ID'

Row Label	Description
NA	NA

Column Label	Description
PIU Case Number	The unique number assigned by the MCO to identify the case.
Medicaid Member ID	Member's Medicaid ID reported as a text string.
Member Name	The name of the Medicaid member. Concatenate the Member's <Last Name>, <First Name><Middle Initial>
Date Complaint or Referral Received	The date the complaint or referral was received by the MCO.

Source of Complaint	Valid codes are to be reported using the list below: Code — Code Description DMS — The Department for Medicaid Services OIG — The Office of Inspector General INT — MCO internal source such as hotline, algorithm, SIU, etc. The Internal Source should be specified. OTH — MCO other source. Source should be specified.
OIG Case Number (if applicable)	The number assigned to the case by OIG or N/A (Applicable only to OIG Source of Complaint). If the source of complaint is OIG, an OIG Case # is required in the OIG Case Number column.
MAT Related (Y or No)	Case involves Medication Assisted Treatment (Y-yes, N-no).
Date Case Opened	Date the case was opened for review by the MCO.
Summary of Complaint with timeframe reviewed	Short description of the complaint with timeframe reviewed.
PIU Action(s) Taken with Date(s)	Brief description of tangible action(s) taken during the reporting period with corresponding date(s). If no action was taken, explain why.
Initial Investigation (Y or N)	Initial Investigation (Y-yes, N-no).
Overpayment Identified	Amount identified during the investigation that may have resulted from fraud, waste and/or abuse.
Referred to DMS (Y, N, E or N/A-Reason)	Investigative report was referred to DMS with MCO recommendation and the MCO requesting permission to take action. Code — Code Description Y — Yes, case referred to DMS. N — No, case has not been referred to DMS. E — Extension Requested N/A-Reason — Referral to DMS not applicable. The reason should be specified if the case was closed (not substantiated).
Date Referred to DMS	The date the action in the previous column was taken (N/A would only be applicable for No and N/A in previous column)
Date Case Closed	The date the case was closed.

[redacted]

Report#:	78	Created:	08/23/2011
Name:	Quarterly Benefit Payments	Last Revised:	08/28/2012
Group:	Financial	Report Status:	Active
Frequency:	Quarterly	Exhibits:	D, E, F
Period:	First day of quarter through the last day of quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Quarterly Benefit Payments report provides MCO financial activity for the Medicaid and Kentucky Children's Health Insurance Program (KCHIP) by MCO Region, Month and State Category of Service. Report only includes financial activity related to Benefits including claims, claim adjustments, mass adjustments, sub-capitation, and other financial payments/recoupment activity not processed as part of claims activity. Categories of Service are grouped by Medicaid Mandatory and Medicaid

Optional Services. Criteria to properly identify and report EPSDT services and KCHIP services are to be applied as outlined below.

Sample Layout:

		MCO Data for LRC Quarterly Report Medicaid (non KCHIP) - Region 01			
COS	COS Description	mm/yyyy	mm/yyyy	mm/yyyy	Qtr. Total
Medicaid Mandatory Services					
02	Inpatient Hospital				$0.00
12	Outpatient Hospital				$0.00
	Subtotal: Mandatory Services	$0.00	$0.00	$0.00	$0.00
Medicaid Optional Services					

03	Mental Hospital				$0.00
04	Renal Dialysis Clinic				$0.00
	Subtotal: Optional Services	$0.00	$0.00	$0.00	$0.00

Total: Mandatory and Optional Services	$0.00	$0.00	$0.00	$0.00

Reinsurance				$0.00
Pharmacy Rebates				$0.00

Grand Total	$0.00	$0.00	$0.00	$0.00

		MCO Data for LRC Quarterly Report KCHIP - Region 01			
COS	COS Description	mm/yyyy	mm/yyyy	mm/yyyy	Qtr. Total

Medicaid Mandatory Services

02	Inpatient Hospital				$0.00
12	Outpatient Hospital				$0.00
	Subtotal: Mandatory Services	$0.00	$0.00	$0.00	$0.00

Medicaid Optional Services

03	Mental Hospital				$0.00
04	Renal Dialysis Clinic				$0.00
	Subtotal: Optional Services	$0.00	$0.00	$0.00	$0.00

Total: Mandatory and Optional Services	$0.00	$0.00	$0.00	$0.00

Reinsurance				$0.00
Pharmacy Rebates				$0.00

Grand Total	$0.00	$0.00	$0.00	$0.00

Reporting Criteria:

General Specifications	Definition
Financial Activity	Payments reported are to be based on date of payment.
EPSDT Services	Multiple Provider Types may provide EPSDT services. Reference Exhibit E for EPSDT Category of Service crosswalk for additional information regarding the identification of EPSDT services.
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Subtotal: Mandatory Services	Calculated Field: Total for all mandatory category of services listed in the report.
Subtotal: Optional Services	Calculated Field: Total for all optional category of services listed in the report.
Total: Mandatory and Optional Services	Calculated Field: Total of 'Subtotal: Mandatory Services' and 'Subtotal: Optional Services'.
Reinsurance	MCO premium payments for stop-loss insurance coverage.
Pharmacy Rebates	Drug Rebates collected by the MCO. 'Pharmacy Rebates' is to be reported as a negative value. Note: The state is responsible for collecting federal drug rebates.
Grand Total	Calculated Field: Total of 'Total: Mandatory and Optional Services', 'Reinsurance' and 'Pharmacy Rebates'.

Column Label	Description
COS	Category of Service: State specific identification of services primarily identified by use of Provider Type. Reference Exhibit D for Category of Service crosswalk.
COS Description	Description for 'COS'
Medicaid (non-KCHIP)	The Medicaid population services are to be reported separately from the KCHIP population services. Populations to be included are based on the Medicaid Eligibility Groups (MEGs): 1. Dual Medicare and Medicaid 2. SSI Adults, SSI Children and Foster Care 3. Children 18 and Under 4. Adults Over 18 Reference Exhibit F for the Medicaid Eligibility Group crosswalk.
KCHIP	The Kentucky Children's Health Insurance Program (KCHIP) population services are to be reported separately from the Medicaid population services.
	Populations to be included are based on the Medicaid Eligibility Groups (MEGs): 3. MCHIP 4. SCHIP Reference Exhibit F for the Medicaid Eligibility Group crosswalk.
Region	Reporting of MCO Enrollee benefit payments is to be based on the Enrollee's region.

Report #:	79	Created:	01/09/2012
Name:	Health Risk Assessments	Last Revised:	05/31/2018
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

This Quarterly Report the MCO shall conduct initial Health Risk Assessments (HRA's) of New Members who have not been enrolled in the prior twelve (12) month period for the purpose, of accessing the Members need for any special health care needs. Enrollment period for new members begins when the MCO receives the member on an HIPAA 834. MCO shall list Health Risk Assessment (HRA's) of Cumulative Members. HRA's should be reported and broken out by Region.

Sample Layout:

Region	New HRA's Initiated Child	New HRA's Initiated Adult	New HRA's Initiated Pregnant Women	Total New HRA's	Cumulative HRA's Initiated Child	Cumulative HRA's Initiated Adult	Cumulative HRA's Initiated Pregnant Women	Total Cumulative HRA's Initiated
1								
2								
3								
4								
5								
6								
7								
8								

Total	0	0	0	0	0	0	0	0

Reporting Criteria:

Row Label	Definition
Region	Provide HRA data by each region.

Column Label	Description
Number of New HRA's Initiated Child (Total)	Provide the total number of New HRA's Initiated for children during the Quarter.
Number of New HRA's Initiated Adult (Total)	Provide the total number of New HRA's Initiated for Adults during this Quarter.
Number of New HRA's Initiated Pregnant (Total)	Provide the total number of New HRA's Initiated for pregnant women during the Quarter.
Total New HRA's Initiated	Provide the total number of New HRA's Initiated for this Quarter.
Number of Cumulative HRA's Initiated Child (Total)	Provide the total number of Cumulative HRA's Initiated for children during this Quarter.
Number of Cumulative HRA's Initiated Adult (Total)	Provide the total number of Cumulative HRA's Initiated for Adults during this Quarter.
Number of Cumulative HRA's Initiated Pregnant Women (Total)	Provide the total number of Cumulative HRA's Initiated for pregnant women during this Quarter .
Total Cumulative HRA's Initiated	Provide the total number of Cumulative HRA's Initiated for this Quarter.

Report#:	84	Created:	12/12/2011
Name:	Quality Assessment and Performance Improvement Project	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	Ongoing		
Due Date:	July 31st		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO's Quality Assessment and Performance Improvement (QAPI) Program shall conform to requirements of 42 CFR 438, Subpart D at a minimum. The MCO shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members. Behavioral Health services, the Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, on-going process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members. The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the MCO. The Contractor's QI structures and processes shall be planned, systematic and clearly defined. Annually, the MCO shall submit the QAPI program description document to the Department for review by July 31 of each contract year.

Report#:	85	Created:	12/12/2011
Name:	Quality Improvement Plan and Evaluation	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	Ongoing		
Due Date:	July 31st		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO's Quality Assessment and Performance Improvement (QAPI) Program shall monitor and evaluate the quality of health care on an ongoing basis and conform to requirements of 42 CFR 438, Subpart D at a minimum. Health care needs such as acute or chronic physical or

behavioral conditions, high volume, and high risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines. Standardized quality indicators shall be used to assess improvement, assure achievement of at least minimum performance levels, monitor adherence to guidelines and identify patterns of over- and under-utilization. The measurement of quality indicators selected by the Contractor must be supported by valid data collection and analysis methods and shall be used to improve clinical care and services.

Annually, the MCO shall submit the Quality Improvement Plan and Evaluation document to the Department for review by July 31 of each contract year.

[redacted]

Report#:	86	Created:	01/09/2012
Name:	Annual Outreach Plan	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Annual	Exhibits:	

Period:	Ongoing		
Due Date:	July 31st		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO shall develop, administer, implement, monitor and evaluate a Member and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to all Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.

Educational and outreach efforts shall be carried on throughout the Contractor's Region. Creative methods will be used to reach Members and community partners. These will include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites.

The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.

Annually, the MCO shall submit the Annual Outreach Plan document to the Department for review by July 31 of each contract year.

Sample Layout:

Quality Improvement Activity	MCO Responsible Staff Person/People	Monitoring Frequency	Quarterly Activity Summary
Activity Name: Objective: Goal: Monitoring:			1st Quarter 20XX: 2nd Quarter 20XX: 3rd Quarter 20XX: 4th Quarter 20XX:
Activity Name: Objective: Goal: Monitoring:			1st Quarter 20XX: 2nd Quarter 20XX: 3rd Quarter 20XX: 4th Quarter 20XX:
Activity Name: Objective: Goal: Monitoring:			1st Quarter 20XX: 2nd Quarter 20XX: 3rd Quarter 20XX: 4th Quarter 20XX:

Reporting Criteria:

Row Label	Description

Activity Name	Provide the name of the QAPI Activity.
Objective	Provide the objective of the QAPI Activity.
Goal	Provide evaluation and track events and quality of care concerns.
Monitoring	Provide MCO staff person or committee responsible for monitoring.

Column Label	**Description**
Quality Improvement Activity	Provide the QAPI Activity along with objective, goal and monitoring for each activity.

MCO Staff Responsible Person or People	Provide the MCO staff person/people responsible for the QAPI activity.
Monitoring Frequency	Provide the monitoring frequency of each QAPI activity.
Quarterly Activity Summary	Provide the quarterly summaries of each QAPI activity

Report#:	90	Created:	10/29/2011
Name:	Performance Improvement Projects Proposal	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	N/A
Period:			
Due Date:	01-SEP		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Performance Improvement Projects Proposal report provides the clinical or non-clinical focus areas for the annual performance improvement projects. The report is to be submitted based on the layout provided in the Health Plan Performance Improvement Project (PIP) document. The sections from the Health Plan Performance Improvement Project (PIP) document that are to be completed for submission of the Performance Improvement Projects Proposal report are:

Cover Page;
MCO and Project Identifiers;
MCO Attestation;
Project Topic;
Methodology; and
Interventions.

Report#:	91	Created:	08/20/2011
Name:	Abortion Procedures	Last Revised:	08/29/2011
Group:	Financial	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of quarter.		
Due Date:	15 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Claim listing of abortion procedures paid by the MCO within a quarter. In the event that no procedures were paid for during the reporting period, the report is still required to be provided. Attachments to be provided with the report include:

Claim Form
Pre-op and/or Post-op Notes
Physician Certificate
Remittance Advice

The Department for Medicaid Services keeps all originals and provides CMS a copy of the Abortion Procedures Report, along with copies of all attachments stamped CONFIDENTIAL with confidential information redacted (except the last four numbers of the SS# as required by CMS).

Sample Layout:

Abortion Procedures							
MCO Region	Member ID	Member DOB	Provider NPI	Claim ICN	First DOS	Last DOS	Paid Amount

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'MCO Region' by 'Member ID' by 'First DOS'.

Row Label	Description
Sub-total	Although not shown on the report template, a subtotal line is to be added after each Region. Sub-total figures are to be reported for Medicaid ID, Claim ICN and Paid Amount columns. Definition for each calculation is the same as listed for the 'Total' but limited to the Region.
Total	Medicaid ID: Total unduplicated Member IDs for the reporting period. Claim ICN: Total count of all claim ICNs for the reporting period. Paid Amount: Total payments for all procedures for the reporting period

Column Label	Description

MCO Region	The MCO Region is determined by the Member's county at the time the service was provided. The MCO shall be under contract to provide Medicaid services in the Region reported. Valid region codes are 01, 02, 03, 04, 05, 06, 07, and 08.
Member ID	The Member's Medicaid ID.
Member DOB	The Member's date of birth.
Provider NPI	The Provider's NPI number as reported on the claim.
Claim ICN	The MCO claim internal control number for the claim being reported.
First DOS	First date of service as reported on the claim.
Last DOS	Last date of service as reported on the claim.
Paid Amount	The total adjudicated claim paid amount by the MCO. Example: A claim adjudicated to pay $100. There is an outstanding A/R in financial for $200. The MCO should report the $100 adjudicated paid amount and not the $0 financial payment.

Report #:	92	Created:	10/29/2011
Name:	Performance Improvement Projects Measurement	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	N/A
Period:			
Due Date:	01-SEP		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Performance Improvement Projects Measurement report provides the baseline, interim, and final results of the Performance Improvement Projects.

The baseline report is to be submitted in the format as outlined in the Health Plan Performance Improvement Project (PIP) document.

The interim report is to be submitted in the format as outlined in the Health Plan Performance Improvement Project (PIP) document.

The final report is to be submitted in the format as outlined in the Health Plan Performance Improvement Project (PIP) document.

A Project Review Guidelines is provided as a separate document which outlines how the PIPs will be evaluated and also provides guidance to the plans on what is expected through the PIP lifetime. The actual scoring of a PIP may differ based on the EQRO contracted with the Department.

Report #:	93	Created:	11/08/2011
Name:	EPSDT CMS-416	Last Revised:	
Group:		Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	Federal Fiscal Year: 01-OCT through 30-SEP		
Due Date:	15-MAR		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The EPSDT CMS-416 report is required annually. The specifications for the EPSDT CMS-416 report shall be in compliance with the most current CMS-416: Annual EPSDT Participation Report and shall be based on Federal Fiscal Year (FFY).

Report #:	94	Created:	11/08/2011
Name:	Member Surveys	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	Calendar Year: 01-JAN through 31-DEC		
Due Date:	31-AUG		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Contractor shall conduct an annual survey of Members' satisfaction with the quality of services provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor. The Contractor shall provide a copy of the current CAHPS survey tool to the Department. Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services. The Department shall review and approve any Member survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used conducting the Member or other special surveys, the number and percentage of the Members to be surveyed, response rates, and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.

Report#:	95	Created:	11/08/2011
Name:	Provider Surveys	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	Calendar Year: 01-JAN through 31-DEC		
Due Date:	31-AUG		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Contractor shall conduct an annual survey of Providers' satisfaction. To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's provider satisfaction survey tool. The Department shall review and approve any Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used conducting the Provider or other special surveys, the number and percentage of the Providers to be surveyed, response rates, and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.

Report#:	96	Created:	11/08/2011
Name:	Audited HEDIS Reports	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	Calendar Year: 01-JAN through 31-DEC		
Due Date:	31-AUG		
Submit To:	National Committee for Quality Assurance (NCQA) Kentucky Department for Medicaid Services		

Description:

The Contractor shall be required to collect and report HEDIS data annually. After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than August 31st.

In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.

For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.

Report #:	97	Created:	10/08/11
Name:	Behavioral Health Adult and Children Populations	Last Revised:	02/05/16
Group:	Behavioral Health	Report Status:	Active
Frequency:	Quarterly, SFY to date	Exhibits:	G
Period:	First day of the State Fiscal Year quarter through the last day of the State Fiscal Year quarter		
Due Date:	30 calendar days following the last day of the reporting period		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:

The report identifies the behavioral health populations to whom services have been provided during the reporting period. Reference Exhibit G for definitions of behavioral health populations. **The populations in this report should be consistent with the populations across all reports.** Count an individual as an adult if at any time during the reporting period the individual was 18 years old or older. Specific sections of this report require a look back of 24 months from the quarter end date of the reporting period. **Both paid and denied claims should be counted when determining if a service has been rendered.**

The populations determined on this report shall be used as the populations for Reports 103, 104, 105, 106 and 110.

Sample Layout:

QE mm/dd/yyyy	
Unduplicated Client Count	Percent of MCO Enrolled
MCO Enrolled	1.00
BH Adults & Children Enrolled	
ADULTS	
All MCO Adults Enrolled	
Adults enrolled during reporting period with BH Diagnosis in 24 months before Qtr End but no BH Services during Reporting Period (1)	
Adults enrolled during the reporting period with BH Diagnosis and BH Services during Reporting Period (2)	
BH Adults General Population [Sum of (1) and (2) above]	
Adults with No BH Diagnosis during 24 months prior to Qtr End who did receive BH Services during Reporting Period	
SMI Enrolled (Subset of BH Adults General Population)	

CHILDREN/YOUTH		
All MCO Children/Youth Enrolled		
Children enrolled during the reporting period with BH Diagnosis in 24 months before Qtr End but no BH Services during Reporting Period (1)		
Children enrolled during the reporting period with BH Diagnosis and BH Services during Reporting Period (2)		
BH Children General Population [Sum of (1) and (2) above]		
Children with No BH Diagnosis who received BH Services during reporting period		
SED Enrolled. (Subset of BH Children General Population)		

SPECIAL POPULATIONS – Subset of Above		
All Pregnant and Post Partum Women		
Adults (18+) - Pregnant and Post Partum Women		
Children/Youth (<18) - Pregnant and Post Partum Women		
All BH Clients Receiving EPSDT Services		
Adults (18+) - BH Clients Receiving EPSDT Services		
Children/Youth (<18) - BH Clients Receiving EPSDT Services		
All PRTF I Clients		

Adults (18+) - PRTF 1 Clients - in state		
Adults (18+) - PRTF 1 Clients - out of state		
Children/Youth (<18) - PRTF I Clients - in state		
Children/Youth (<18) - PRTF I Clients - out of state		

Reporting Criteria:

General Specifications	Definition
DateFormat	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy Quarterly Unduplicated count of all Members from the first day of the State Fiscal Year quarter to the last day of the State Fiscal Year quarter.

	State Unduplicated count of Members from the first day of the State Fiscal Fiscal Year through the last day of the State Fiscal Year (July 1- Year June 30).
Percent	Report percentages as decimals, e.g., 5.25% should be reported as .0525.
Sort Order	The report is to be sorted in order as shown above in sample layout.

Row Label	Description
MCO Enrolled	Include all persons who were members during the reporting period.
BH Adults and Children/Youth Enrolled	An unduplicated count of MCO enrolled members who meet the criteria for any of the four Behavioral Health populations according to Exhibit G.
Adults	This is a header row
All MCO Adults Enrolled	An unduplicated count of all MCO enrolled Members that are age 18 or older.
Adults with BH Diagnosis not receiving BH services	An unduplicated count of all MCO Members enrolled during the reporting period that meet the criteria outlined in Measure 1 in Exhibit G. This is a subset of the row "All MCO Adults Enrolled".
Adults with BH Diagnosis receiving BH Services	An unduplicated count of all MCO Members enrolled during the reporting period that meet the criteria outlined in Measure 2 in Exhibit G. This is a subset of the row "All MCO Adults Enrolled".
TOTAL BH ADULTS	The sum of the previous two rows
Adults without BH Diagnosis receiving BH Services	An unduplicated count of all MCO enrolled Members without a diagnosis as outlined in Exhibit G who received a behavior health service. Refer to the Fee for Service Schedules to identify behavioral health services.
SMI Enrolled	An unduplicated count of all MCO users that are SMI. The SMI Behavioral Health Population is defined in Exhibit G: Behavioral Health Populations. This is a subset of row "BH Adults Enrolled".
Children/Youth	This is a header row
All MCO Children/Youth Enrolled	An unduplicated count of all MCO enrolled Members that are under age 18.
Children/Youth with BH Diagnosis not receiving BH Services	An unduplicated count of all MCO Members enrolled during the reporting period that meet the criteria outlined in Measure 1 in Exhibit G. This is a subset of the row "All MCO Children/Youth Enrolled".
Children/Youth with BH Diagnosis receiving BH Services	An unduplicated count of all MCO Children/Youth enrolled during the reporting period that meet the criteria outlined in Measure 2 in Exhibit G. This is a subset of the row "All MCO Children/Youth Enrolled".
TOTAL BH Children/Youth	The sum of the previous two rows
Children/Youth without BH Diagnosis receiving BH Services	An unduplicated count of all MCO enrolled Children/Youth that meet the criteria outlined in Exhibit G.
SED Enrolled	An unduplicated count of all MCO users that are SED. The SED Behavioral Health Population is defined in Exhibit G: Behavioral Health Populations. "This is a subset of "BH Children/Youth Enrolled".
SPECIALPOPULATIONS	This is a header row
Pregnant and Postpartum Women	This is a header row
All Pregnant and Postpartum Women	The unduplicated count of pregnant or postpartum members for which a behavioral health service was provided by the MCO or the MCO subcontractor during the reporting period. Refer to the Fee for Service Schedules to identify behavioral health services. This row is the sum of the following two rows which distinguish between adults and children/youth.
Adults (18+) – Pregnant and Postpartum Women	The unduplicated count of pregnant or postpartum members that are age 18 or older for which a behavioral health service was provided by the MCO or the MCO subcontractor during the reporting period. Refer to the Fee for Service Schedules to identify behavioral health services. This row is a subset of the row "All Pregnant and Postpartum Women".
Children/Youth (<18) – Pregnant and Postpartum Women	The unduplicated count of pregnant or postpartum members that are less than 18 years old for which a behavioral health service was provided by the MCO or the MCO subcontractor during the reporting period. Refer to the Fee for Service Schedules to identify behavioral health services. Refer to industry

	standards for a list of behavioral health services. This row is a subset of the row "All Pregnant and Postpartum Women".
EPSDT Service Recipients (BH)	This is a header row
All BH Clients Receiving EPSDT Services	The unduplicated count of behavioral health members for which an EPSDT service was provided by the MCO or the MCO subcontractor during the reporting period. Refer to the Fee for Service Schedules to identify EPSDT services. This row is the sum of the following two rows which distinguish between adults and children/youth.
Adults (18+) – BH Clients Receiving EPSDT Services	The unduplicated count of behavioral health members that are age 18 or older for which an EPSDT service was provided by the MCO or the MCO subcontractor during the reporting period. Refer to the Fee for Service Schedules to identify EPSDT services. This row is a subset of the row "All BH Clients Receiving EPSDT Services".
Children/Youth (<18) – BH Clients Receiving EPSDT Services	The unduplicated count of behavioral health members that are less than 18 years of age for which an EPSDT service was provided by the MCO or the MCO subcontractor during the reporting period. Refer to the Fee for Service Schedules to identify EPSDT services. This row is a subset of the row "All BH Clients Receiving EPSDT Services".
PRTF I Clients	This is a header row
All BH Clients Receiving Services at a PRTF I Facility	The unduplicated count of members served at any PRTF I facility by the MCO or the MCO subcontractor during the reporting period. This row is the sum of the following four rows which distinguish between adults and children/youth and between in state and out of state facilities.
Adults (18+) – BH Clients Receiving Services at a PRTF I Facility In State	The unduplicated count of members that are age 18 and older served at any Kentucky PRTF I facility by the MCO or the MCO subcontractor during the reporting period. This row is a subset of the row "All BH Clients Receiving Services at a PRTF I Facility".
Adults (18+) – BH Clients Receiving Services at a PRTF I Facility Out of State	The unduplicated count of members that are age 18 and older served at any PRTF I facility outside of Kentucky by the MCO or the MCO subcontractor during the reporting period. This row is a subset of the row "All BH Clients Receiving Services at a PRTF I Facility".
Children/Youth (<18) – BH Clients Receiving Services at a PRTF I Facility In State	The unduplicated count of members that are less than age 18 served at any Kentucky PRTF I facility by the MCO or the MCO subcontractor during the reporting period. This row is a subset of the row "All BH Clients Receiving Services at a PRTF I Facility".
Children/Youth (<18) – BH Clients Receiving Services at a PRTF I Facility Out of State	The unduplicated count of members that are less than age 18 served at any PRTF I facility outside of Kentucky by the MCO or the MCO subcontractor during the reporting period. This row is a subset of the row "All BH Clients Receiving Services at a PRTF I Facility".

Column Label	**Description**
QE mm/dd/yyyy	Quarter Ending (QE) is the last day of the State Fiscal Year quarter displayed in the format mm/dd/yyyy. This column is to be populated in all reports in space provided; contents should apply to the last quarter ending and the quarter ending date should be correctly displayed in the space provided. Quarter Unduplicated count of all users from the first day of the quarter to the last day of the quarter of the State Fiscal Year.

Report #:	119	Created:	01/19/12
Name:	Mental Health Statistics Improvement Project Adult Survey Report	Last Revised:	2/12/2015
Group:	Behavioral Health	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	State Fiscal Year: 07/01 through 06/30		
Due Date:	180 days after State Fiscal Year End		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:
The MCO shall annually implement the Mental Health Statistics Improvement Program (MHSIP) Adult Survey. The behavioral health member satisfaction survey requirement shall be satisfied by the Contractor by administering the 28-Item Mental Health Statistics Improvement Program (MHSIP) Adult Survey plus eight (8) additional items for the Social Connectedness and Functioning National Outcome Measures (for adult behavioral health members).

The MCO may contact the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to obtain a current version of the survey tools. The Contractor shall submit a plan for administration (sampling strategy, survey methodology, etc.) to DBHDID prior to survey administration . DBHDID shall review and approve any behavioral health member survey instruments and plan for administration and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results in the format prescribed. Survey results shall include counts of Members surveyed by MCO Region and report percentages of Members who report positively about the following domains:

Access
Quality and Appropriateness
Outcomes
Treatment Planning
General Satisfaction with Services

Sample Layout:

Provider Type	SFY Survey Completed	General Satisfaction	Access	Quality	Participation	Outcomes	Social Connectedness	Functioning

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Provider Type	All Billing Provider Types are to be considered. Billing Provider Type is designated with a state specific two (2) character field. Crosswalk of Provider Type and Provider Specialty to each Provider Description is provided in Exhibit A: Provider Type and Specialty Crosswalk.
SFY Survey Completed	The State Fiscal Year within which the survey was completed. Use format YYYY.
General Satisfaction	The Mean Score of the domain.
Access	The Mean Score of the domain.
Quality	The Mean Score of the domain.
Participation	The Mean Score of the domain.
Outcomes	The Mean Score of the domain.
Social Connectedness	The Mean Score of the domain.
Functioning	The Mean Score of the domain.

[redacted]

Report #:	120	Created:	01/19/12
Name:	Youth Services Satisfaction Caregiver Survey Report	Last Revised:	2/12/2015
Group:	Behavioral Health	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	State Fiscal Year: 07/01 through 06/30		
Due Date:	180 days after the end of State Fiscal Year		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:
The MCO shall annually implement the Youth Services Satisfaction Caregiver Survey (YSSF) . The YSSF requirement shall be satisfied by the Contractor by administering the 21-item Youth Services Survey Family Version (YSS-F) plus additional 4 items for the Social Connectedness National Outcome Measure (for parents /caregiver of child members). The Contractor may contact the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to obtain a current version of the survey tools. The MCO shall submit a plan for administration (sampling strategy, survey methodology, etc.) to DBHDID prior to survey administration. DBHDID shall review and approve any Behavioral Health member survey instruments and plan for administration and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results in the format prescribed. Survey results shall include counts of Members surveyed by MCO Region and report percentages of Youth Members who report positively about the following domains:

Access
Outcomes
Treatment Planning
Family Members Reporting high Cultural Sensitivity of Staff
General Satisfaction with Services

Sample Layout:

Provider Type	SFY Survey Completed	General Satisfaction	Access	Cultural Sensitivity	Participation	Outcomes	Social Connectedness	Functioning

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy

Provider Type	All Billing Provider Types are to be considered. Billing Provider Type is designated with a state specific two (2) character field. Crosswalk of Provider type and Provider Specialty to each Provider Description is provided in Exhibit A: Provider Type and Specialty Crosswalk.
SFY Survey Completed	The State Fiscal Year within which the survey was completed. Use format YYYY.
General Satisfaction	The Mean Score of the domain.
Access	The Mean Score of the domain.
Cultural Sensitivity	The Mean Score of the domain.
Participation	The Mean Score of the domain.
Outcomes	The Mean Score of the domain.
Social Connectedness	The Mean Score of the domain.
Functioning	The Mean Score of the domain.

[redacted]

Report#:	126	Created:	08/28/2012
Name:	FQHC and RHC	Last Revised:	02/27/2013
Group:	Utilization	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of the quarter through the last day of the quarter.		
Due Date:	45 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The FQHC and RHC report provides the total amount paid to each Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) per month. All Providers with a specialty of FQHC or RHC are to be reported.

Sample Layout:

Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Utilization								
Specialty	Provider Medicaid ID	Provider Name	Month	# Unduplicated Claims Excluding Crossovers	Total Amt Paid- Claims Excluding Crossovers	TPL Amount Listed	# Unduplicated Crossover Claims	Total Amt Paid - Crossover Claims

Reporting Criteria:

General Specifications	Definition
Sort Order	The report is to be sorted in ascending order: <Specialty> by <Provider Medicaid ID> by <Month>

Row Label	Description
NA	

Column Label	Description
Specialty	The Provider specialty. Valid values are FQHC and RHC
Provider Medicaid ID	Medicaid ID assigned by the Department
Provider Name	Provider name associated with the Provider Medicaid ID as listed in MMIS
Month	The month that the payments were made to the Provider. Format to be reported is<YYYY/MM>.
# Unduplicated Claims Excluding Crossovers	Total number by Medicaid ID of unduplicated claims for the quarter. Do not include Crossover Claims
Total Amt Paid- Claims Excluding Crossovers	Total dollars paid for the total number of unduplicated claims excluding crossovers listed in the previous column.
TPL Amount Listed	Total amount of any Third Party payment listed for the number of unduplicated claims excluding crossovers listed in column three.
# Unduplicated Crossover Claims	Total number by Medicaid ID of unduplicated crossover claims for the quarter.
Total Amt Paid - Crossover Claims	Total dollars paid for the total number of unduplicated crossover claims listed in the previous column.

Report#:	127	Created:	08/28/2012
Name:	Statement on Standards for Attestation Engagements (SSAE) No. 16	Last Revised:	NA
Group:	Audit/Internal Control	Report Status:	Active
Frequency:	Annual or as Appropriate	Exhibits:	NA
Period:	As required by APA		
Due Date:	30 days following the first calendar quarter (April 30)		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should provide the Statement on Standards for Attestation Engagements (SSAE) No. 16 Type II audit that addresses the engagements conducted by services providers on service organization for reporting design control and operational effectiveness.

Report#:	173	Created:	07/12/2018
Name:	MCO-PBM Compliance Report for POS Transactions	Last Revised:	
Group:	Pharmacy	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	State Fiscal Year July 1 – June 30.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Monthly summary of Ownership & Related Entities with details for each MCO, PBM and the related entities; Monthly Financial Detail; Cumulative Financial Detail; Related Entity Financial Detail; Related Entity Financial Detail; Pharmacy Type Financial Detail. List Executive Staff Titles; Relationship Titles; MCO and the PBM shall each submit a legal structure chart.

Sample Layout:

Ownership and Related Entities of the PBM

MCO Disclosure

MCO Name	ENTER ON SHEET 2
Address 1	
Address 2	
City	
State	
Zip Code	
Phone	
email	

Subsidiaries	Relationship to MCO

MCO Officers/Ownership

Name Title

PBM Disclosure

PBM Name	
Address 1	
Address 2	
City	
State	
Zip Code	
Phone	
email	

PBM Parent	Relationship to PBM

PBM Officers/Ownership

Name	Title

Related Entities of the PBM

Entity Name	
Address 1	
Address 2	
City	
State	
Zip Code	
Phone	
email	
Business Type	

Relationship to PBM

Relationship End Date (if applicable)

Related Entities of the PBM Officers/Ownership

Name	Title	Detail for "Other"

Monthly PBM Financial Detail

MCO Name: _____

Report Run Date: _____

Reporting Period From: _____

Reporting Period To: _____

NOTE: See "Data Dictionary and Terminology" tab for detail on reporting items.

Jan 2017 Financial Information

Item #		
1	Medicaid $ paid to PBM	$ -
2	Medicaid $ paid to PBM, not paid to pharmacies	$ -

		Ingredient Cost		Dispensing Fee		Other Fees		
		median	mean	median	mean	median	mean	total claims
3	Average reimbursement by claim, PBM to pharmacies of common ownership	$ -	$ -	$ -	$ -	$ -	$ -	0
4a	Average reimbursement by claim, PBM to pharmacies with 11 or more locations for fills up to a 34 days supply	$ -	$ -	$ -	$ -	$ -	$ -	0
4b	Average reimbursement by claim, PBM to pharmacies with 11 or more locations for fills greater than a 34 days supply	$ -	$ -	$ -	$ -	$ -	$ -	0
5a	Average reimbursement by claim, PBM to pharmacies with 10 or fewer locations for fills up to a 34 days supply	$ -	$ -	$ -	$ -	$ -	$ -	0
5b	Average reimbursement by claim, PBM to pharmacies with 10 or fewer locations for fills greater than a 34 days supply	$ -	$ -	$ -	$ -	$ -	$ -	0

		DI Fees	Other Assessments /Charges
6	Total remuneration fees charged to pharmacies of common ownership, by fee type	$ -	$ -
7	Total remuneration fees charged to pharmacies with 11 or more locations, by fee type	$ -	$ -
8	Total remuneration fees charged to pharmacies with 10 or fewer locations, by fee type	$ -	$ -

2017 Cumulative Financial Detail

MCO Name: _____

Report Run Date: _____

Reporting Period From: _____

Reporting Period To: _____

NOTE: See "Data Dictionary and Terminology" tab for detail on reporting items.

Item #		
1	Medicaid $ paid to PBM	$ -
2	Medicaid $ paid to PBM, not paid to pharmacies	$ -

		Ingredient Cost		Dispensing Fee		Other Fees		
		median	mean	median	mean	median	mean	total claims
3	Average reimbursement by claim, PBM to pharmacies of common ownership	$ 0		$ -	$ -	$ -	$ -	
4a	Average reimbursement by claim, PBM to pharmacies with 11 or more locations for fills up to a 34 days supply	$ 0	$ -	$ -	$ -	$ -	$ -	
4b	Average reimbursement by claim, PBM to pharmacies with 11 or more locations for fills greater than a 34 days supply	$ -	$ -	$ -	$ -	$ -	$ -	
5a	Average reimbursement by claim, PBM to pharmacies with 10 or fewer locations for fills up to a 34 days supply	$ -	$ -	$ -	$ -	$ -	$ -	
5b	Average reimbursement by claim, PBM to pharmacies with 10 or fewer locations for fills greater than a 34 days supply	$ -	$ -	$ -	$ -	$ -	$ -	

		DI Fees	Other Assessments /Charges
6	Total remuneration fees charged to pharmacies of common ownership, by fee type	$ -	$ -

7	Total remuneration fees charged to pharmacies with 11 or more locations, by fee type	$ -	$ -
8	Total remuneration fees charged to pharmacies with 10 or fewer locations, by fee type	$ -	$ -

Related Entity Financial Detail

	Jan 2017							
	Average reimbursement by claim from PBM to pharmacies of common ownership						Total assessments charged to pharmacies of common ownership	
	Ingredient Cost		Dispensing Fee		Other Fees			
Entity Name	median	mean	median	mean	median	mean	DI Fees	Other Assessments /Charges

Pharmacy Type Financial Detail

	Jan 2017							
	Average reimbursement by claim from PBM to pharmacies by pharmacy type						Total assessments charged to pharmacies by pharmacy type	
	Ingredient Cost		Dispensing Fee		Other Fees			
Pharmacy Type	median	mean	median	mean	median	mean	DI Fees	Other Assessments /Charges
Specialty								
Mail Order / Home Delivery								
LTC / Institutional								
Maintenance Supply (≥ 90 DS)								

Addendum 1

Kentucky Department for Medicaid Services

#173_MCO-PBM Compliance Report for POS Transactions

Executive Staff Titles
Behavioral Health Director
Board Member (Board of Directors) Chairman
(Board of Directors)
Chief Accounting Officer
Chief Administrative Officer
Chief Business Development Officer
Chief Business Officer
Chief Commercial Officer
Chief Compliance Officer
Chief Data Officer
Chief Executive
Chief Executive Officer
Chief Financial Officer
Chief Information Officer
Chief Information Security Officer
Chief Investment Officer
Chief Marketing Officer
Chief Medical Director
Chief Medical Officer
Chief Networking Officer
Chief of Staff
Chief Operations Officer
Chief Pharmaceutical Officer
Chief Privacy Officer
Chief Procurement Officer
Chief Revenue Officer
Chief Security Officer
Chief Technical Officer
Deputy General Manager
Deputy President
Director
Executive Chairman
Executive Vice President
Finance Director
Financial Control Officer
General Manager
Operations Director
Other Executive Staff
Owner
Partner

President
Proprietor
Senior Executive Vice President
Senior Vice President
Vice Chairman (Board of Directors)
Vice President

Addendum 2

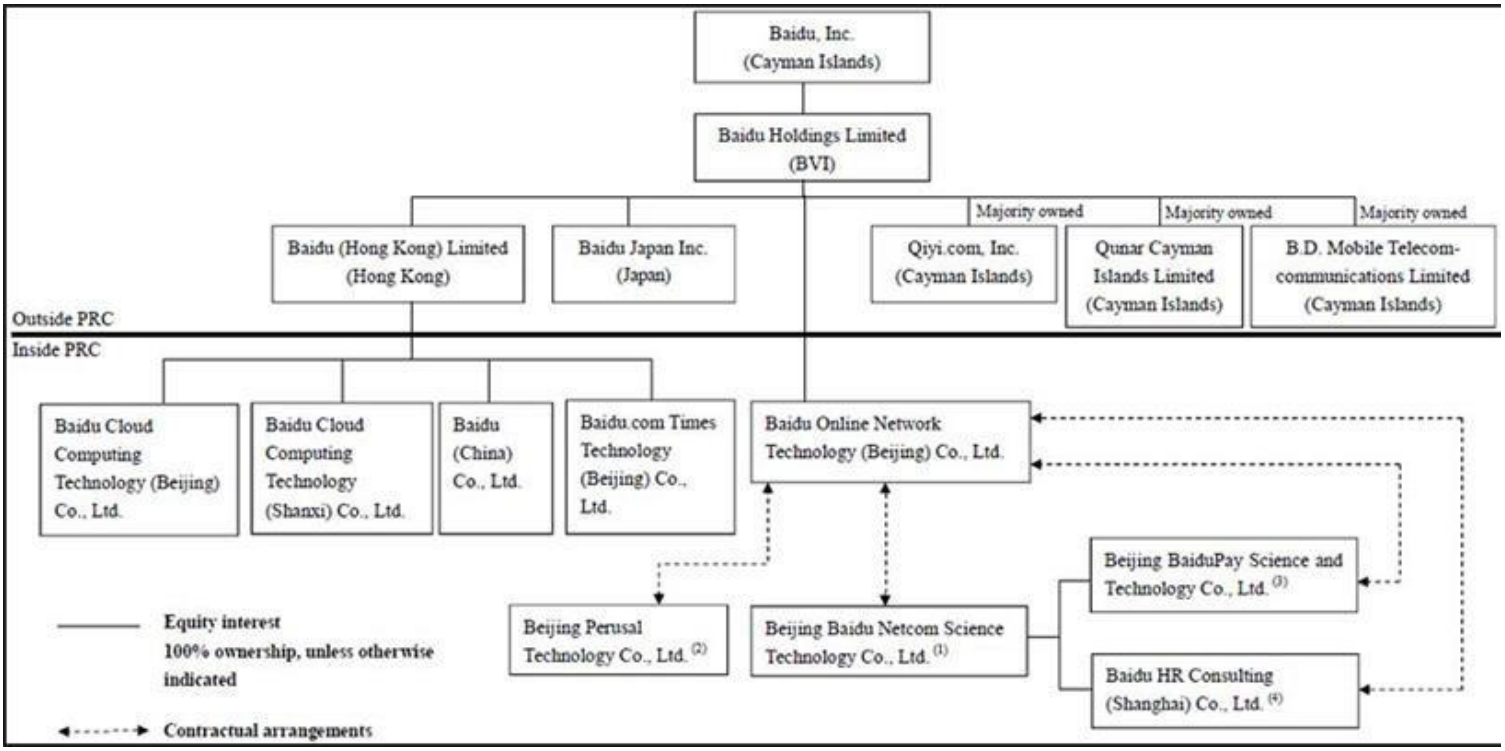
Kentucky Department for Medicaid Services #173_MCO-PBM Compliance Report for POS Transactions
Relationship Titles
MCO Holding Company Other
Parent Co-Subsidiary
Parent Jointly Held Companies PBM Jointly
Held Companies PBM Management Company
PBM Parent Company
PBM Subsidiary Subcontractor/Vendor
Wholly-owned Subidiary

Addendum 3

Kentucky Department for Medicaid Services

#173_MCO-PBM Compliance Report for POS Transactions

Example_Legal Structure Chart



Kentucky Department for Medicaid Services

#173_MCO-PBM Compliance Report for POS Transactions

All MCO Cumulative Financial Detail

Reporting Period From: _____

Reporting Period To: _____

Item #		
1	Medicaid $ paid to PBM	$ -
2	Medicaid $ paid to PBM, not paid to pharmacies	$ -

		Ingredient Cost		Dispensing Fee		Other Fees		
		median	mean	median	mean	median	mean	total claims
3	Average reimbursement by claim, PBM to pharmacies of common ownership	$ -	$ -	$ -	$ -	$ -	$ -	
4a	Average reimbursement by claim, PBM to pharmacies with 11 or more locations for fills up to a 34 days supply	$ -	$ -	$ -	$ -	$ -	$ -	
4b	Average reimbursement by claim, PBM to pharmacies with 11 or more locations for fills greater than a 34 days supply	$ -	$ -	$ -	$ -	$ -	$ -	
5a	Average reimbursement by claim, PBM to pharmacies with 10 or fewer locations for fills up to a 34 days supply	$ -	$ -	$ -	$ -	$ -	$ -	
5b	Average reimbursement by claim, PBM to pharmacies with 10 or fewer locations for fills greater than a 34 days supply	$ -	$ -	$ -	$ -	$ -	$ -	

		DI Fees	Other Assessments /Charges
6	Total remuneration fees charged to pharmacies of common ownership, by fee type	$ -	$ -
7	Total remuneration fees charged to pharmacies with 11 or more locations, by fee type	$ -	$
8	Total remuneration fees charged to pharmacies with 10 or fewer locations, by fee type	$ -	$ -

Kentucky Department for Medicaid Services

#173_MCO-PBM Compliance Report for POS Transactions

Instructions

Tab 1: ***Instructions:*** **Read Only**.

Tab 2: ***Report ID Information:*** **Enter** the identifying information for your organization.

Tab 3: ***Ownership & Related Entities:*** **Enter** the details for each MCO, PBM, and the related entities.

- Managed care health plans should replicate their information on the Annual Disclosure of Ownership form as submitted to the Kentucky Department for Medicaid Services' Provider Enrollment Department.
- To identify the officers/ownership for the entities of the PBM, include all national level and state level contacts.
- The **"Toggle Utilities" button** at the top right hand corner of the tab, should be utilized for additional "Related Entities" and "Officers/Ownership" information.
- Input information for all shaded cells.
- Use drop-down menus to complete "Relationship Type" and "Executive Titles".

Tab 4: ***Monthly Financial Detail:*** **Enter** the monthly financial details by month and entity.

Tab 5: ***Cumulative Financial Detail:*** This tab self populates; you do not need to enter information on this tab.

Tab 6: ***Related Entity Financial Detail:*** **Enter** the monthly financial details by month and entity for the Kentucky Medicaid dollars spent.

Tab 7: ***Pharmacy Type Financial Detail:*** **Enter** the monthly financial details by month and pharmacy type for the Kentucky Medicaid dollars spent.

Tab 8: ***Data Dictionary and Terminology.***

Tab 9: ***Addendum 1_Executive Staff Titles.***

Tab 10: ***Addendum 2_Relationship Titles.***

Tab 11: ***Addendum 3_Example_Legal Structure Chart:*** The **MCO and the PBM** are shall each submit a legal structure chart.

NOTES:

1. Reporting data should be at the **date of service** level.
2. All dates must be entered in the following format: **mm/dd/yyyy**.
3. When data is complete and accurate, save this workbook under the following: **MCOName_PBM Compliance Report_Calendar Year (yyyy)**.
4. Transmit completed workbook to the Kentucky Department for Medicaid Services via **SharePoint**.
5. For each new report that is submitted, the previous reported months of data will need to be refreshed.
6. The macro security will need to be set to **"enable all macros"** in order to use this template.

REPORT DUE DATE: This report will be due by the 15th of the calendar month following the report period calendar month/year.

Report #:	200	Created:	03/31/2012
Name:	834 Reconciliation Reports	Last Revised:	04/08/2019
Group:	HIPPA 834 Reconciliation Reports	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:	First day of month through the last day of month		
Due Date:	By the 15th of the month following the report period		
Submit To:	Kentucky Department for Medicaid Services		

Description:

When the MCO identifies:

- a Member that the MCO believes is not eligible for MCO enrollment;
- conflicting Member data elements;
- a potential duplicate Member assignment;

the MCO shall identify the Member on the 'Ineligible Assignment' report.

When the potential ineligible member is identified through receipt of a HIPAA 834 transaction (daily or monthly) the MCO shall use the data received on the HIPAA 834 to complete the report. The MCO Comments field shall start with the date of the HIPAA 834 transaction.

When the potential ineligible member, conflicting data elements, or potential duplicate Members assignments are identified through other means than the HIPAA 834 transaction, the MCO shall complete the report using the active data from the MCO Eligibility system.

The MCO may include in the MCO Comment field details as to why the MCO believes the Member is a duplicate if the MCO deems the information critical for DMS review.

Sample Layout:

THIS SECTION TO BE COMPLETED BY THE MCO									
#	Member Last Name	Member First Name	SSN	Medicaid ID#	Secondary ID	MCO Effective Date	MCO End Date	County	
1									
2									
3									

Program Code	Status Code	Data Element #1	Data Element #2	Data Element #3	Data Element #4	MCO Comments	Action	Action Date	DMS Comments (To Be completed by DMS)

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy unless otherwise stated.

Row Label	Description
NA	NA
Column Label	**Description**
#	Counter to easily identify record.
SSN	Social Security Number of the Medicaid Member. To be reported as a 9 character text string without any dashes.
Member Last Name	The Member's last name.
Member First Name	The Member's first name.
SSN	Social Security Number of the Medicaid Member. To be reported as a 9 character text string without any dashes.
Medicaid ID	The Members Medicaid ID. To be reported as a text string.
Secondary ID	The Members MCO assigned ID number (Optional)
MCO Effective Date	The Effective Date of the MCO assignment that the MCO believes to be invalid.
MCO End Date	The End Date of the MCO assignment that the MCO believes to be invalid.
County	The three digit county code of the Member to be reported as a 3 character text string.
Program Code	The Member's one or two character Program Code that corresponds to the assignment that the MCO believes to be invalid. To be reported as a text string.
Status Code	The Member's two character Status Code that corresponds to the assignment that the MCO believes to be invalid. To be reported as a text string.
Data Element #1	Member information that may conflict with other reported Member information. For example: If a Program Code does not match a Foster Care indicator then the Program Code value should be populated.
Data Element #2	Member information that may conflict with other reported Member information. To follow the example from Data Element #1: If a Program Code does not match a Foster Care indicator then the Foster Care Indicator should be populated.
Data Element #3	Member information that may conflict with other reported Member information.
Data Element #4	Member information that may conflict with other reported Member information.
MCO Comments	When the activity was identified through a HIPAA 834 transaction the HIPAA 834 transaction date is to be included as the first comment. Other comments may be included when the MCO believes it will assist the DMS in review of the report.
Action	The research results reported by DMS.
Action Date	The date the DMS reviewer reviewed and, if necessary, modified the Member's Information.
DMS Comments	Description of the reason why the "Action" was taken.

Report #:	220	Created:	03/31/2012
Name:	Newborn	Last Revised:	
Group:	HIPAA 834 Reconciliation Reports	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:			
Due Date:	15th of the Month		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO shall submit the 'Newborn' report (MCO Report # 220) monthly for all newborns that are thirty (30) days or older for which the MCO has not received a HIPAA 834 enrollment transaction.

Sample Layout:

	THIS SECTION TO BE COMPLETED BY THE MCO									TO BE COMPLETED BY DMS				
#	Newborn Last Name	Newborn First Name	Date of Birth	Gender	Newborn County	Mother's Member Number or SSN	Mother's Last Name	Mother's First Name	Days Old	Action	Action Date	30 Day Action	30 Day Action Date	Comments
1														
2														
3														
4														

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy unless otherwise stated.

Row Label	Description
NA	NA

Column Label	Description
#	Counter to easily identify record.
Newborn Last Name	The Newborn's last name.
Newborn First Name	The Newborn's first name.
Date of Birth	The Newborn's date of birth.
Gender	The Newborn's gender.
Newborn County	The three digit county code of the Newborn to be reported as a 3 character text string.
Mother's Member Number or SSN	Provide Newborn Mother's Medicaid ID or Social Security Number associated with the mother's enrollment information from the state system. Medicaid ID to be reported as a text string. SSN to be reported as a 9 character text string without any dashes.
Mother's Last Name	Provide Newborn's Mother last name if available at time of the report associated with

	with the mother's enrollment information from the state system.
Mother's First Name	Provide Newborn's Mother first name if available at time of the report associated with the mother's enrollment information from the state system.
Days Old	Provide Newborn's age as number of days old. The Newborn on their date of birth is to be counted as one (1) day old.
Action	The research results reported by DMS. Valid values and their description are: NNE: The Newborn is not enrolled in Medicaid. Enrollment process has been initiated. NE not MCO: The Newborn is enrolled in Medicaid but is not eligible for enrollment in the MCO. NE MCO: The Newborn is enrolled in Medicaid and is enrolled with the MCO. NE add MCO The Newborn is enrolled in Medicaid and has now been assigned to the MCO.
Action Date	The date the DMS reviewer initially reviewed the Newborns Medicaid eligibility and, if necessary, assigned the Newborn to the MCO. It is not the date of enrollment. Rather it is the date that MCAPS and/or MMIS were updated with the assignment.
30 Day Action	For 'Action' values of NNE, DMS will update the status of the Newborn Medicaid enrollment. Valid values and their description of that action are: NE and MCO: The Newborn was enrolled in Medicaid and assigned to the MCO. NE not MCO: The Newborn was enrolled in Medicaid but was not assigned to the MCO. NNE: The Newborn was not enrolled in Medicaid.
30 Day Action Date	The date the DMS reviewer updated the Newborn Medicaid Enrollment and, if necessary, assigned the Newborn to the MCO. It is not the date of enrollment. Rather it is the date that MCAPS and/or MMIS were updated with the assignment.
Comments	Description of the reason why the 'Action' and/or '30 Day Action' was taken. The Newborn Medicaid Id will be provided For Newborns enrolled in Medicaid that are assigned to the MCO ('30 Day Action' value of NE and MCO).

Report#:	230	Created:	03/31/2012
Name:	Capitation Payment Request	Last Revised:	
Group:	HIPAA 820 Reconciliation Reports	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:	Months prior to or equal to the MMIS Reconciliation Month		
Due Date:	45 Days after receipt of the HIPAA 820 containing the MMIS Reconciliation Month		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO shall submit the 'Capitation Payment Request' report of all members that the MCO identifies for which payment has not been received. Only those months equal to or prior to the MMIS Managed Care Reconciliation Month (MMIS Recon Month) are to be reported.

Sample Layout:

Instructions for submitting the report are in Appendix P – MCO CAPITATION RECONCILIATION INBOUND/OUTBOUND FILE LAYOUTS

Report #:	250	Created:	03/31/2012
Name:	Capitation Adjustments Request	Last Revised:	
Group:	HIPAA 834 Reconciliation Reports	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:	Months prior to or equal to the MMIS Reconciliation Month		
Due Date:	45 Days after receipt of the HIPAA 820 containing the MMIS Reconciliation Month		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO shall submit the 'Capitation Adjustment Requests' report for Members that the MCO believes an inaccurate capitation payment was made. The capitation adjustment requests are limited to the capitation payments made for the MMIS Recon Month or capitation payments that were made as retroactive payments that will not be adjusted though the MMIS Recon processes because the capitation month is prior to the MMIS Recon Month.

Sample Layout:

Instructions for submitting the report are in Appendix P – MCO CAPITATION RECONCILIATION INBOUND/OUTBOUND FILE LAYOUTS

Report #:	251	Created:	04/10/2018
Name:	Provider Credentialing Status Report	Last Revised:	06/11/18
Group:	Provider Enrollment	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

This report documents the status of all providers by Medicaid Provider Type with the activity related to Provider Credentialing and Enrollments of Providers by the MCO Providers who have applied for credentialing/enrollment in multiple Provider Types are to be reported under each Provider Type.

Sample Layout:

MCO Provider Enrollment and Credentialing							
NPI	Last/Entity Name	First Name	Provider Type	Provider Type Description	Date Credentialing Process Initiated by Provider	Current Status	Explanation

Criteria

General Specifications	Definition
Date format	All dates are to be in the following format : mm/dd/yyyy
Sorting	The report should be sorted by "Date" with the oldest entry first.

Column Label	Description
NPI	The Provider's NPI
Last/Entity Name	For an individual, report the last name of the Provider; for a Provider Group/Entity, report the Group/Entity Name
First Name	The Provider's first name
Provider Type	Provider Type Code based on Kentucky's recognized Provider Types
Provider Type Description	Description for Provider Type
Date Credentialing Process Initiated by Provider	The date credentialing process initiated by provider is the Receipt Date that the MCO receives the enrollment form from the Provider

Current Status	The status of the Provider's application. Entries may include, but are not limited to, Approved, Closed, Denied, In Process, Pending, Holding for Corrections, Returned to the Provider-Corrections, Returned to the Provider-Already Enrolled, Returned to the Provider-Provider Type Not Available, and Returned to the Provider-Application Withdrawn.
Explanation	Short description of the Status

Report #:	252	Created:	05/18/2018
Name:	IMD Report Institution for Mental Diseases 15 Days	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:
This report documents the status of all MCO recipients who have been admitted to IMD that Exceeds 15 Days and all recipients who have been admitted to IMD 15 Days or Under.

Sample Layout:

IMD Report Exceeds 15 Days

Name of Recipient	Medicaid ID	Facility 1	Admit Date	Discharge Date	Number of Days PER CALENDAR MONTH that are over 15	Comments

IMD Report 15 Days or Under

Name of Recipient	Medicaid ID	Facility 1	Admit Date	Discharge Date	Number of Days PER CALENDAR MONTH that are 15 Days or Under	Comments

Reporting Criteria:

General Specifications	Definition
Date format	All dates are to be in the following format : mm/dd/yyyy
Sorting	The report should be sorted by "Date" with the oldest entry first.

Column Label	Description
Member Name	The name of the Medicaid member. Concatenate the Member's <Last Name>, <First Name> <Middle Initial>
Medicaid Member ID	Member's Medicaid ID reported as a text string.
Facility 1	Facility Name
Admit Date	Date the member was admitted to IMD
Discharge Date	Date the member was discharged from IMD
Number of Days PER CALENDAR MONTH that are over 15	Total Number of Days PER CALENDAR MONTH that member was in IMD that are over 15
Number of Days PER CALENDAR MONTH that are 15 Days or Under	Total Number of Days PER CALENDAR MONTH that member was in IMD that are 15 Days or Under
Comments	Additional Comments

Report #:	253	Created:	04/11/2019
Name:	IMD Report Institution for Mental Diseases-Residential Treatment for Substance Use Disorder (SUD) 30 Days	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

This report documents the status of all MCO recipients who have been admitted to IMD-Residential Treatment for Substance Use Disorder (SUD) that Exceeds 30 Days and all recipients who have been admitted to IMD-Residential Treatment for Substance Use Disorder (SUD) 30 Days or Under.

Sample Layout:

IMD Report Exceeds 30 Days

Name of Recipient	Medicaid Member ID	Provider Number and Provider Name	Facility Name if Different from Provider Name	Provider Address or Facility Address if Different from Provider Address	Admit Date	Discharge Status	Discharge Date	Number of Days PER CALENDAR MONTH that are over 30 Days	Comments

IMD Report 30 Days or Under

Name of Recipient	Medicaid Member ID	Provider Number and Provider Name	Facility Name if Different from Provider Name	Provider Address or Facility Address if Different from Provider Address	Admit Date	Discharge Status	Discharge Date	Number of Days PER CALENDAR MONTH that are 30 Days or Under	Comments

Reporting Criteria:

General Specifications	**Definition**
Date format	All dates are to be in the following format : mm/dd/yyyy
Sorting	The report should be sorted by “Date” with the oldest entry first.

Column Label	**Description**
Member Name	The name of the Medicaid member. Concatenate the Member’s <Last Name>, <First Name> <Middle Initial>
Medicaid Member ID	Member’s Medicaid ID reported as a text string.
Provider Number and Provider Name	Medicaid ID assigned by the Department and Provider name associated with the Provider Medicaid ID as listed in MMIS
Facility Name if different from Provider Name	Facility Name if different from Provider Name. Several Facilities can be listed under one Provider Number and Provider Name.
Provider Address or Facility Address if Different from Provider Address	The Physical address of the Provider or the Physical address of Facility if Different from Provider Address
Admit Date	Date the member was admitted to IMD
Discharge Status	Place member was discharged to
Discharge Date	Date the member was discharged from IMD
Number of Days PER CALENDAR MONTH that are over 30	Total Number of Days PER CALENDAR MONTH that member was in IMD that are over 30
Number of Days PER CALENDAR MONTH that are 30 Days or Under	Total Number of Days PER CALENDAR MONTH that member was in IMD that are 30 Days or Under
Comments	Additional Comments

Report#:	300	Created:	04/12/2019
Name:	Quarterly LRC Report	Last Revised:	
Group:	Financial	Report Status:	Active
Frequency:	Quarterly	Exhibits:	D, E, F
Period:	First day of quarter through the last day of quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Quarterly Benefit Payments report provides MCO financial activity for the Medicaid and Kentucky Children's Health Insurance Program (KCHIP) by MCO Quarterly Months and State Category of Service; Monthly Eligibles: Average Monthly Cost per Eligible Report only includes financial activity related to Benefits including claims, claim adjustments, mass adjustments, sub-capitation, and other financial payments/recoupment activity not processed as part of claims activity. Categories of Service are grouped by Medicaid Mandatory and Medicaid

Optional Services. Criteria to properly identify and report EPSDT services and KCHIP services are to be applied as outlined below.

List Amount withheld to meet DOI Reserve Requirements and List Any Distribution of Moneys Received or Retained in Excess of these Reserve Requirements

List 12-Month Averages Medicaid (non KCHIP) and list 12-Month Averages KCHIP on the last Quarter of the year. This report will start in July and end in June. Report 1st Quarter July, August, September, 2nd Quarter October, November, December, 3rd Quarter January, February, March, 4th Quarter April, May, June. The 4th quarter report ending in June-List the 12-Month Averages for Medicaid (non KCHIP) and list the 12-Month Averages KCHIP.

Sample Layout:

MCO Data for LRC Quarterly Report

Medicaid (non KCHIP) - All Regions

COS	COS Description	mm/yyyy	mm/yyyy	mm/yyyy	Qtr. Total	Monthly Eligibles	Average Monthly Cost per Eligibles	12-Month Averages
						mm/yyyy	mm/yyyy	
Medicaid Mandatory Services								
02	Inpatient Hospital				$0.00			
12	Outpatient Hospital				$0.00			
	Subtotal: Mandatory Services	$0.00	$0.00	$0.00	$0.00			
Medicaid Optional Services								
03	Mental Hospital				$0.00			
04	Renal Dialysis Clinic				$0.00			
	Subtotal: Optional Services	$0.00	$0.00	$0.00	$0.00			
	Total: Mandatory and Optional Services	$0.00	$0.00	$0.00	$0.00			
	Reinsurance				$0.00			
	Pharmacy Rebates				$0.00			
	Amount withheld to meet DOI Reserve Requirements				$0.00			
	Any Distribution of Moneys Received or Retained in Excess of these Reserve Requirements				$0.00			
	Grand Total	$0.00	$0.00	$0.00	$0.00			

MCO Data for LRC Quarterly Report

KCHIP - All Regions

COS	COS Description	mm/yyyy	mm/yyyy	mm/yyyy	Qtr. Total	Monthly Eligibles	Average Monthly Cost per Eligible	12-Month Averages
						mm/yyyy	mm/yyyy	

Medicaid Mandatory Services

02	Inpatient Hospital				$0.00
12	Outpatient Hospital				$0.00
	Subtotal: Mandatory Services	$0.00	$0.00	$0.00	$0.00

Medicaid Optional Services

03	Mental Hospital				$0.00
04	Renal Dialysis Clinic				$0.00
	Subtotal: Optional Services	$0.00	$0.00	$0.00	$0.00

Total: Mandatory and Optional Services	$0.00	$0.00	$0.00	$0.00

Reinsurance				$0.00
Pharmacy Rebates				$0.00
Amount withheld to meet DOI Reserve Requirements				$0.00
Any Distribution of Moneys Received or Retained in Excess of these Reserve Requirements				$0.00

Grand Total	$0.00	$0.00	$0.00	$0.00

Reporting Criteria:

General Specifications	Definition
Financial Activity	Payments reported are to be based on date of payment.
EPSDT Services	Multiple Provider Types may provide EPSDT services. Reference Exhibit E for EPSDT Category of Service crosswalk for additional information regarding the identification of EPSDT services.
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Subtotal: Mandatory Services	Calculated Field: Total for all mandatory category of services listed in the report.
Subtotal: Optional Services	Calculated Field: Total for all optional category of services listed in the report.
Total: Mandatory and Optional Services	Calculated Field: Total of 'Subtotal: Mandatory Services' and 'Subtotal: Optional Services'.
Reinsurance	MCO premium payments for stop-loss insurance coverage.
Pharmacy Rebates	Drug Rebates collected by the MCO. 'Pharmacy Rebates' is to be reported as a negative value. Note: The state is responsible for collecting federal drug rebates.
Amount withheld to meet DOI Reserve Requirements	The amount of money withheld to meet DOI Reserve Requirements
Any Distribution of Moneys Received or Retained in Excess of these Reserve Requirements	The amount of money Received or Retained in Excess of these Reserve Requirements
Grand Total	Calculated Field: Total of 'Total: Mandatory and Optional Services', 'Reinsurance' and 'Pharmacy Rebates'.

Column Label	Description
COS	Category of Service: State specific identification of services primarily identified by use of Provider Type. Reference Exhibit D for Category of Service crosswalk.
COS Description	Description for 'COS'

Medicaid (non-KCHIP)	The Medicaid population services are to be reported separately from the KCHIP population services. Populations to be included are based on the Medicaid Eligibility Groups (MEGs): 5. Dual Medicare and Medicaid 6. SSI Adults, SSI Children and Foster Care 7. Children 18 and Under 8. Adults Over 18 Reference Exhibit F for the Medicaid Eligibility Group crosswalk.
KCHIP	The Kentucky Children's Health Insurance Program (KCHIP) population services are to be reported separately from the Medicaid population services. Populations to be included are based on the Medicaid Eligibility Groups (MEGs): 1. MCHIP 6. SCHIP Reference Exhibit F for the Medicaid Eligibility Group crosswalk.
Monthly Eligibles	Enter the number of Monthly Eligibles
Average Monthly Cost per Eligible	Enter the Average Monthly Cost per Eligible
12-Month Averages Medicaid (non KCHIP)	Enter 12-Month Averages Medicaid (non KCHIP) on the 4th Quarter Report ending in June.
12-Month Averages KCHIP	Enter 12-Month Averages KCHIP on the 4th Quarter Report ending in June.

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APPENDIX L. MCO PROVIDER NETWORK FILE LAYOUT (EFFECTIVE 11-07-12)

Submit one delimited text file per network.
Submit one record for each provider to include the values indicated in the layout.

Field	Data Type	Length	Description	Valid Values
Provider Type	Character	2	Medicaid Provider Type	Utilize valid values from sheet titled Medicaid Provider Types
Provider Contracted	Character	1	Valid values are C or L. C=provider has a signed contract to be a participating provider in the network or L=provider has signed a letter of intent stating they will be a participating provider in the network.	Valid values are C or L. C=provider has a signed contract to be a participating provider in the network or L=provider has signed a letter of intent stating they will be a participating provider in the network.
Provider License	Character	10	Must be submitted for physicians and leave blank if physician is licensed in a state other than Kentucky.	Must be submitted for physicians and leave blank if physician is licensed in a state other than Kentucky.
National Provider Identifier (NPI)	Character	10	Must be submitted for providers required to have an NPI.	Must be submitted for providers required to have an NPI.
Medicaid Provider ID	Character	10	Provider ID assigned by Kentucky Medicaid. Must be submitted - if known.	Provider ID assigned by Kentucky Medicaid. Must be submitted - if known.
Primary Specialty Code	Character	3	Medicaid Provider Specialty	Utilize valid values from sheet titled

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				Medicaid Provider Specialties.
Secondary Specialty Code	Character	3	Medicaid Provider Specialty	Utilize valid values from sheet titled Medicaid Provider Specialties
Name	Character	50	If a physician name, enter as last name, first name, MI	If a physician name, enter as last name, first name, MI.
Address Line 1	Character	50	Location street address line 1	DO NOT SUBMIT PO BOX OR MAILING ADDRESS. THIS MUST BE LOCATION ADDRESS!
Address Line 2	Character	50	Location street address line 2	DO NOT SUBMIT PO BOX OR MAILING ADDRESS. THIS MUST BE LOCATION ADDRESS!
City	Character	50	Location city	
State	Character	2	Location state	
Zip Code	Character	5	Location zip code	
County Code	Character	3	Location county	County Code of the Provider's location address. See the following list for Kentucky County Codes.
Phone Number	Character	15	Phone number excluding dashes	Do not include dashes, etc.
Latitude	Character	11	Latitude of the Provider's location address. Precision to the 6th digit. Must be in format 99.999999	Latitude of the Provider's location address. Precision to the 6th digit. Must be in format 99.999999
Longitude	Character	11	Longitude of the	Longitude of the

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			Provider's location address. Precision to the 6th digit. Must be in format - 99.999999	Provider's location address. Precision to the 6th digit. Must be in format - 99.999999
PCP Specialist or Both	Character	1	Valid entries are P, S or B. P=PCP, S=Specialty, B=Both. Leave blank for all other providers.	Valid entries are P, S or B. P=PCP, S=Specialty, B=Both. Leave blank for all other providers.
PCP Open or Closed Panel	Character	1	Mandatory for PCP. Valid entries are O or C. O=Open, C=Closed. Leave blank for all other providers.	Mandatory for PCP. Valid entries are O or C. O=Open, C=Closed. Leave blank for all other providers.
PCP Panel Size	Character	9	PCP Provider's maximum panel size	PCP Provider's maximum panel size
PCP Panel Enrollment	Character	9	PCP Provider's current panel enrollment count	PCP Provider's current panel enrollment count
Spanish	Character	1	Y = yes	Y - yes
Language 1	Character	3	Language code	See the following codes
Language 2	Character	3	Language code	See the following codes
Language 3	Character	3	Language code	See the following codes
Language 4	Character	3	Language code	See the following codes
MCO Medicaid Provider ID	Character	10	Provider ID assigned to the MCO by Kentucky Medicaid	Provider ID assigned to the MCO by Kentucky Medicaid.
Effective Date	Character	8 (CCYYMMDD)	Effective date that the provider joined the MCO and can provide services	Effective date that the provider joined the MCO and can provide services.
End Date	Character	8	Last date the	Last date the

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		(CCYYMMDD)	provider is contracted with the MCO. (If provider contract is open ended send 22991231.)	provider is contract with the MCO. (If provider contract is open ended send 22991231.)
Is Included in directory	Character	1	Y - yes, provider will be included in the state as well as MCO network directories. N - No, provider is still part of the network, but will not be included in the state as well as MCO network directories.	Y - yes, provider will be included in the state as well as MCO network directories. N - No, provider is still part of the network, but will not be included in the state as well as MCO network directories.
Reserved1		20	Reserved	Reserved
Reserved2		20	Reserved	Reserved
Reserved3		20	Reserved	Reserved
Reserved4		20	Reserved	Reserved
Reserved5		20	Reserved	Reserved

Provider Types:

Provider Type Code	Provider Type Description
01	General hospital
02	Mental Hospital
04	Psychiatric Residential Treatment Facility
10	ICF/MR Clinic
11	ICF/MR
12	Nursing Facility
13	Specialized Children Service Clinics
14	MFP Pre-Transition Services
15	Health Access Nurturing Development Svcs
17	Acquired Brain Injury
20	Preventive & Remedial Public Health
21	School Based Health Services
22	Commission for Handicapped Children
23	Title V/DSS
24	First Steps/Early Int.
25	Targeted Case Management
27	Adult Targeted Case Management
28	Children Targeted Case Management
29	Impact Plus

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30	Community Mental Health
31	Primary Care
32	Family Planning Service
33	Support for Community Living (SCL)
34	Home Health
35	Rural Health Clinic
36	Ambulatory Surgical Centers
37	Independent Laboratory
38	Lab & X-Ray Technician
39	Dialysis Clinic
40	EPSDT Preventive Services
41	Model Waiver
42	Home and Community Based Waiver
43	Adult Day Care
44	Hospice
45	EPSDT Special Services
46	Home Care Waiver
47	Personal Care Waiver
50	Hearing Aid Dealer
52	Optician (528 - Optical clinic)
54	Pharmacy
55	Emergency Transportation
56	Non-Emergency Transportation
57	Net (Capitation)
58	Net Clinic (Capitation)

60	Dentist - Individual
61	Dental - Group
64	Physician Individual
65	Physician - Group
70	Audiologist
72	Nurse Midwife
73	Birthing Centers
74	Nurse Anesthetist
77	Optometrist - Individual
78	Certified Nurse practitioner
80	Podiatrist
82	Clinical Social Worker
85	Chiropractor
86	X-Ray / Misc. Supplier
87	Physical Therapist
88	Occupational Therapist
89	Psychologist
90	DME Supplier
91	CORF (Comprehensive Out-patient Rehab Facility)
92	Psychiatric Distinct Part Unit
93	Rehabilitation Distinct Part Unit
95	Physician Assistant
96	HMO/PHP
98	MCO (Managed Care Organization)
99	Not on File

Medicaid Provider Specialties:

Provider Specialt y Code	Provider Specialty Description
010	Acute Care
012	Rehabilitation
014	Critical Access
015	Children's Specialty
016	Emergency

017	Ventilator Hospital
011	Psychiatric
013	Residential Treatment Center
038	ICF/MR Clinic
030	Nursing Facility
031	ICF/MR > 6 Beds
032	Pediatric Nursing Facility

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033	Residential Care Facility
034	ICF/MR < 6 Beds
035	Skilled Nursing Facility
036	Respite Care - Facility Based
037	Assisted Living
179	Brain Injury
131	Specialized Children's Service Clinics
141	MFP $15,000 Bucket
142	MFP $2000 Visa Pro-card Expenditures
143	MFP $2000 Check Expenditures
159	Health Access Nurturing Development Svcs Group
151	Health Access Nurturing Development Svcs
201	General Preventive Care
209	General Preventive Care Group
120	School Board
228	Commission For Handicapped Children Group
229	Commission For Handicapped Children
239	Title V/DSS
238	Title V/DSS Group
249	First Steps Early Int.
248	First Steps Early Int. Group
211	HIV Case Manager
214	High Risk Pregnant Women
215	TB Case Mgmt
216	OJA Targeted Case Management
221	MH Case Mgmt All Ages
222	MH Case Mgmt, Over 21, Public

223	MH Case Mgmt, Over 21, Contracted
224	MH Case Mgmt, Over 21, Private
226	MH Case Mgmt, Under 21, Contracted
227	MH Case Mgmt, Under 21, Private
225	MH Case Mgmt, Under 21, Public
291	Impact Plus DMH
292	Impact Plus DCBS
299	Impact Plus Other
110	Outpatient Mental Health Clinic
111	Community Mental Health Center (CMHC)
114	Health Service Provider in Psychology (HSPP)
118	Mental Health - DMHSAS
080	Federally Qualified Health Clinic (FQHC)
082	Medical Clinic
308	Family Planning Clinic Group
083	Family Planning Clinic
039	Supports for Community Living
050	Home Health Agency
051	Specialized Home Nursing Services
210	Care Coordinator for Pregnant Women
081	Rural Health Clinic (RHC)
020	Ambulatory Surgical Center (ASC)
280	Independent Lab
281	Mobile Lab
861	Other Laboratory And X-Ray

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300	Free-standing Renal Dialysis Clinic
183	EPSDT Preventive Services
411	Model Waiver 1
412	Model Waiver 2
561	Home and Community Based Waiver
410	Adult Day Care
060	Hospice
150	Chiropractor
455	Prescribed Pediatric Extended Care Facility (PPEC)
550	EPSDT Services - OBSOLETE
551	General hospital
552	Psychiatric Hospital
553	Psychiatric Residential Treatment Facility
554	Commission for Handicapped Children
555	Children Targeted Case Management
556	Community Mental Health
557	Physician
558	Home Health
559	Rural Health Clinic
560	Independent Laboratory
563	Hearing Aid Dealer
564	Optician
565	Pharmacy
567	Dentist - Individual
568	Dental - Group
569	Physician Individual
570	Physician - Group
571	Audiologist
573	Optometrist
574	Certified Nurse practitioner
575	Podiatrist

579	DME Supplier
580	CORF
999	None on File
463	Provider of Case Management Services Only
464	Provider of Homemaker and Personal Care Services Only
465	Provider of Home Adaptations Only
466	Homemaker Personal Care & Home Adaptation Services
470	Provider of Case Management Services Only
471	Provider of Personal Care Coordination Services Only
472	Provider of Personal Care Assistance Services Only
473	Both Personal Care Coordinator and Care Assist Services
220	Hearing Aid Dealer
509	Hearing Aid Dealer Group
180	Optometrist
190	Optician
528	Multi-Specialty Group - Optician
240	Pharmacy
260	Ambulance
261	Air Ambulance
262	Bus
263	Taxi
264	Common Carrier (Ambulatory)
265	Common Carrier (Non-ambulatory)
266	Family Member / Private Auto
661	AMBULANCE Non-

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	Emergency
073	NET (Non-Emergency Transportation)
671	Net Cap
672	NET - DOT
270	Endodontist
271	General Dentistry Practitioner
272	Oral Surgeon
273	Orthodontist
274	Pediatric Dentist
275	Periodontist
276	Oral Pathologist
277	Prosthesis
610	Multi-Specialty Group - Dental
543	Teleradiology
112	Psychologist
310	Allergist
311	Anesthesiologist
312	Cardiologist
313	Cardiovascular Surgeon
314	Dermatologist
315	Emergency Medicine Practitioner
316	Family Practitioner
317	Gastroenterologist
318	General Practitioner
319	General Surgeon
320	Geriatric Practitioner
321	Hand Surgeon
322	Internist
323	Neonatologist
324	Nephrologist
325	Neurological Surgeon
326	Neurologist
327	Nuclear Medicine Practitioner
328	Obstetrician/Gynecologist

329	Oncologist
330	Opthalmologist
331	Orthopedic Surgeon
332	Otologist, Laryngologist, Rhinologist
333	Pathologist
334	Pediatric Surgeon
335	Maternal Fetal Medicine
336	Physical Medicine and Rehabilitation Practitioner
337	Plastic Surgeon
338	Proctologist
339	Psychiatrist
340	Pulmonary Disease Specialist
341	Radiologist
342	Thoracic Surgeon
343	Urologist
344	General Internist
345	General Pediatrician
346	Dispensing Physician
347	Radiation Therapist
348	Osteopathy
544	Immunology
545	Colon and Rectal Surgery
546	Medical Genetics
547	Preventive Medicine
293	Medicare Clinic
650	Multi-Specialty Group - Physician
200	Audiologist
709	Audiologist Group
095	Certified Nurse Midwife
729	Nurse Midwife Group
913	Birthing Centers
094	Certified Registered Nurse Anesthetist (CRNA)
749	Multi-Specialty Group - Nurse Anesthetist

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779	Multi-Specialty Group - Optometrist
090	Pediatric Nurse Practitioner
091	Obstetric Nurse Practitioner
092	Family Nurse Practitioner
093	Nurse Practitioner (Other)
789	Multi-Specialty Group - Nurse Practitioner
140	Podiatrist
809	Podiatrist Group
115	Certified Clinical Social Worker
116	Certified Social Worker
829	Clinic Social Worker Group
859	Chiropractor Group
251	Assistive Technology
542	Other Lab Toxicology

170	Physical Therapist
879	Physical Therapist Group
171	Occupational Therapist
889	Occupational Therapist Group
899	Psychologist Group
250	DME/Medical Supply Dealer
911	CORF
912	Other CORF Group
040	Rehabilitation Facility
100	Physician Assistant
101	Anesthesiology Assistant
959	Physician Assistant Group
071	Managed Care Organization (MCO)
072	IHS Case Manager

Kentucky County Codes:

County Code	County Description
001	Adair
002	Allen
003	Anderson
004	Ballard
005	Barren
006	Bath
007	Bell
008	Boone
009	Bourbon
010	Boyd
011	Boyle
012	Bracken
013	Breathitt
014	Breckinridge
015	Bullitt
016	Butler
017	Caldwell
018	Calloway

019	Campbell
020	Carlisle
021	Carroll
022	Carter
023	Casey
024	Christian
025	Clark
026	Clay
027	Clinton
028	Crittenden
029	Cumberland
030	Daviess
031	Edmonson
032	Elliott
033	Estill
034	Fayette
035	Fleming
036	Floyd
037	Franklin
038	Fulton
039	Gallatin

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040	Garrard
041	Grant
042	Graves
043	Grayson
044	Green
045	Greenup
046	Hancock
047	Hardin
048	Harlan
049	Harrison
050	Hart
051	Henderson
052	Henry
053	Hickman
054	Hopkins
055	Jackson
056	Jefferson
057	Jessamine
058	Johnson
059	Kenton
060	Knott
061	Knox
062	Larue
063	Laurel
064	Lawrence
065	Lee
066	Leslie
067	Letcher
068	Lewis
069	Lincoln
070	Livingston
071	Logan
072	Lyon
073	McCracken
074	McCreary
075	McLean
076	Madison
077	Magoffin
078	Marion

079	Marshall
080	Martin
081	Mason
082	Meade
083	Menifee
084	Mercer
085	Metcalfe
086	Monroe
087	Montgomery
088	Morgan
089	Muhlenberg
090	Nelson
091	Nicholas
092	Ohio
093	Oldham
094	Owen
095	Owsley
096	Pendleton
097	Perry
098	Pike
099	Powell
100	Pulaski
101	Robertson
102	Rockcastle
103	Rowan
104	Russell
105	Scott
106	Shelby
107	Simpson
108	Spencer
109	Taylor
110	Todd
111	Trigg
112	Trimble
113	Union
114	Warren
115	Washington
116	Wayne
117	Webster

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118	Whitley
119	Wolfe
120	Woodford
121	Guardianship
200	Out of State
220	Alabama
221	Alaska
222	Arizona
223	Arkansas
224	California
225	Colorado
226	Connecticut
227	Delaware
228	District Col
229	Florida
230	Georgia
231	Hawaii
232	Idaho
233	Illinois
234	Indiana
235	Iowa
236	Kansas
237	Louisiana
238	Maine
239	Maryland
240	Massachusetts
241	Michigan
242	Minnesota
243	Mississippi
244	Missouri
245	Montana
246	Nebraska
247	Nevada
248	New Hampshire
249	New Jersey
250	New Mexico
251	New York
252	North Carolina
253	North Dakota
254	Ohio
255	Oklahoma
256	Oregon
257	Pennsylvania
258	Puerto Rico
259	Rhode Island
260	South Carolina
261	South Dakota
262	Tennessee
263	Texas
264	Utah
265	Vermont
266	Virginia
267	Virgin Islands
268	Washington
269	West Virginia
270	Wisconsin
271	Wyoming
296	Canada

Language Codes:

Language Code	Language Description
001	Abkhazian
002	Afan (Oromo)
003	Afar
004	Afrikaans
005	Albanian
006	Amharic
007	Arabic
008	Armenian
009	Assamese
010	Zerbaijani
011	Bashkir
012	Basque

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013	Bengali; Bangla
014	Bhutani
015	Bihari
016	Bislama
017	Breton
018	Bulgarian
019	Burmese
020	Byelorussian
021	Cambodian
022	Catalan
023	Chinese
024	Corsican
025	Croatian
026	Czech
027	Danish
028	Dutch
029	enclish
030	Esperonto
031	Estonian
032	Faroese
033	Fiji
034	Finnish
035	French
036	Frisian
037	Galican
038	Georgian
039	German
040	Greek
041	Greenlandic
042	Guarani
043	Gujarati
044	Hausa
045	Hebrew
046	Hindi
047	Hungarian
048	Icelandic
049	Indonesian
050	Interlingua
051	Ingerlingue

052	Inuktitut
053	Inupiak
054	Irish
055	Italian
056	Japanese
057	Javanese
058	Kannada
059	Kashmiri
060	Kazakh
061	Kinyarwanda
062	Kirghiz
063	Kurundi
064	Korean
065	Kurdish
066	Laothian
067	Latin
068	Latvian; Lettish
069	Lingala
070	Lithuanian
071	Macedonian
072	Malagasy
073	Malay
074	Malayalam
075	Maltese
076	Maori
077	Marathi
078	Moldavian
079	Mongolian
080	Nauru
081	Nepali
082	Norwegian
083	Occitan
084	Oriya
085	Pashto;Pushto
086	Persian (Farsi)
087	Polish
088	Portuguese
089	Punjabi
090	Quechua

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091	Rhaeto-Romance
092	Romanian
093	Russian
094	Samoan
095	Sangho
096	Sanskrit
097	Scot Gaelic
098	Serbian
099	Serbo-Croatian
100	Seotho
101	Setswana
102	Shona
103	Sindhi
104	Singhalese
105	Siswati

106	Slovak
107	Slovenian
108	Somali
110	Sundanese
111	Swahili
112	Swedish
113	Tagalog
114	Tajik
115	Tamil
116	Tatar
117	Telugu
118	Thai
119	Tibetan
120	Tigrinya

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PROVIDER MASTER EXTRACT FILE LAYOUT FOR MCOS

Description:

Full extract of Medicaid providers active in the last 6 months

Destination(s):

Each MCO

Interface Id:

524

Frequency

Daily

Criteria:

All providers that have been active within the last six months

Header Record

Field	Data Type	Start	End	Length	Description
RECORD ID	Char	1	2	2	Value 'HH' to denote header record
CREATE DATE	Char	3	12	10	Date file is created in MM/DD/CCYY format
FILE SENDER	Char	13	52	40	'KENTUCKY DEPARTMENT OF MEDICAID SERVICES'
FILE DESCRIPTION	Char	53	92	40	'INTERCHANGE PROVIDER FILE'
TIME PERIOD – MONTH	Char	93	94	2	Month this file is to be processed in MM format.
TIME PERIOD - YEAR	Char	95	98	4	Year this file is to be processed in CCYY format.
FILE DESTINATION	Char	99	138	40	*'MCO NAME'*
DESTINATION FILE NAME	Char	139	168	30	prd962**xx**.dat (where xx stands for **01** for Coventry Health and Life Insurance Company **02** for WellCare Of Kentucky Inc.

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					03 for Kentucky Spirit Health Plan **04** for Humana Caresource **05** for Passport Health Plan
FILE ORIGIN	Char	169	208	40	‘KYMMIS CORPORATION, FRANKFORT, KENTUCKY’
PROD OR TEST	Char	209	209	1	Indicates a production or test file - ’P’ or ‘T’
RECORD LENGTH	Number	210	214	5	Length of detail record (600 bytes)
CREATE PROGRAM	Char	215	222	8	‘PRVP962D’
NEWLINE	Char	223	223	1	Newline character = 0x0a

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Detail Record

Field	Data Type	Start	End	Length	Description
RECORD ID	Char	1	2	2	Value 'DD' to denote detail record
PROVIDER TYPE	Char	3	4	2	Two character code designating the Provider type (not changing from Legacy)
PROVIDER NUMBER	Char	5	14	10	Legacy (converted) providers will continue to have an 8 byte ID with spaces padded on the end, newly enrolled providers will have a 10 byte id.
MEDICAID BEGIN DATE	Char	15	22	8	CCYYMMDD format
MEDICAID END DATE	Char	23	30	8	CCYYMMDD format
STATUS CODE (END REASN)	Char	31	31	1	Code describing the reason for termination.
NAME TYPE	Char	32	32	1	'P' for Personal, 'B' for Business. If 'B' the name will be strung together in the Last, First, and MI fields.
LAST NAME	Char	33	58	26	Last Name
FIRST NAME	Char	59	70	12	First Name
MIDDLE INITIAL	Char	71	71	1	Middle Initial
TAX ID TYPE	Char	72	72	1	'F' for FEIN, 'S' for SSN
TAX ID NUMBER	Char	73	81	9	IRS Tax ID Number
SSN	Char	82	90	9	Provider's Social Security Number
LICENSE NUMBER	Char	91	100	10	Provider's License Number.
LICENSE END DATE	Char	101	108	8	License's expiration date in CCYYMMDD format.
BOARD CERTIFIED SPECIALTY	Char	109	111	3	Do not currently have this data. Field is filled with spaces.
LANGUAGE 1	Char	112	114	3	HIPAA defined language code. If not on file, field will be filled with spaces. (English will be assumed and not sent)

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LANGUAGE 2	Char	115	117	3	HIPAA defined language code. If not on file, field will be filled with spaces. (English will be assumed and not sent)
LANGUAGE 3	Char	118	120	3	HIPAA defined language code. If not on file, field will be filled with spaces. (English will be assumed and not sent)
HOSPITAL AFFILIATION 1	Char	121	130	10	Medicaid number of hospital. (Do not currently have this data). Field will be filled with spaces.
HOSPITAL AFFILIATION 2	Char	131	140	10	Medicaid number of hospital. (Do not currently have this data). Field will be filled with spaces.
HOSPITAL AFFILIATION 3	Char	141	150	10	Medicaid number of hospital. (Do not currently have this data). Field will be filled with spaces.
NPI	Char	151	160	10	National Provider Identifier
NPI EFFECTIVE DATE	Char	161	168	8	Date NPI becomes effective.
NPI END DATE	Char	169	176	8	Date NPI is terminated.
NP2 (if Any)	Char	177	186	10	National Provider Identifier 2
NPI2 EFFECTIVE DATE	Char	187	194	8	Date NPI2 becomes effective.
NPI2 END DATE	Char	195	202	8	Date NPI2 is terminated.
NP3 (if Any)	Char	203	212	10	National Provider Identifier 3
NPI3 EFFECTIVE DATE	Char	213	220	8	Date NPI3 becomes effective.
NPI3 END DATE	Char	221	228	8	Date NPI3 is terminated.
NUMBER OF BEDS	Char	229	234	6	Number of beds
PRACTICE TYPE	Char	235	235	1	Practice Type values ‘A’ thru ‘H’.
PROVIDER SPECIALTY	Char	236	238	3	Provider primary specialty code.
TITLE	Char	239	253	15	Example ‘MD’, ‘DDS’, etc…
PRIMARY ADDRESS 1	Char	254	283	30	Primary (physical) address line 1.
PRIMARY ADDRESS 2	Char	284	313	30	Primary (physical) address line 2.

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PRIMARY CITY	Char	314	343	30	Primary (physical) address city.
PRIMARY STATE	Char	344	345	2	Primary (physical) address state.
PRIMARY ZIP	Char	346	350	5	Primary (physical) address zip code.
PRIMARY ZIP+4	Char	351	354	4	Primary (physical) address zip code extension.
MAILING ADDRESS 1	Char	355	384	30	Mailing address line 1.
MAILING ADDRESS 2	Char	385	414	30	Mailing address line 2.
MAILING CITY	Char	415	444	30	Mailing address city.
MAILING STATE	Char	445	446	2	Mailing address state.
MAILING ZIP	Char	447	451	5	Mailing address zip code.
MAILING ZIP+4	Char	452	455	4	Mailing address zip code extension.
REMIT ADDRESS 1	Char	456	485	30	Remittance (pay-to) address line 1.
REMIT ADDRESS 2	Char	486	515	30	Remittance (pay-to) address line 2.
REMIT CITY	Char	516	545	30	Remittance (pay-to) address city.
REMIT STATE	Char	546	547	2	Remittance (pay-to) address state.
REMIT ZIP	Char	548	552	5	Remittance (pay-to) address zip code.
REMIT ZIP+4	Char	553	556	4	Remittance (pay-to) address zip code extension.
GROUP AFFILIATION	Char	557	566	10	Medicaid provider number of group this individual provider is associated with.
PHONE NUMBER	Char	567	576	10	Provider's telephone number. In '9999999999' format.
DEA NUMBER	Char	577	585	9	Provider's DEA number.
UPIN	Char	586	591	6	Provider's UPIN Number.
TAXONOMY	Char	592	601	10	Provider's primary taxonomy code.
PROVIDER ATTESTATION	Char	602	602	1	Provider Attestation indicator – 'Y' or blank
PROVIDER ATTEST. EFF DATE	Char	603	610	8	Provider Attestation effective date
PROVIDER	Char	611	618	8	Provider Attestation end date

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ATTEST. END DATE					
VACC FOR CHILDREN PROV	Char	619	619	1	Vaccine-for-Children Provider indicator – 'Y' or blank
VFC PROV CURRENT EFF DATE	Char	620	627	8	Vaccine for Children Provider current effective date
VFC PROV CURRENT END DATE	Char	628	635	8	Vaccine for Children Provider current end date
VFC PROV PREV. EFF DATE	Char	636	643	8	Vaccine for Children Provider previous effective date
VFC PROV PREV END DATE	Char	644	651	8	Vaccine for Children Provider previous end date
GROUP MEMBER INDICATOR	Char	652	652	1	Indicates whether the Provider is a member of a group – 'Y' = group 'N' = individual
NPI4	Char	653	662	10	National Provider Identifier 4
NPI4 EFFECTIVE DATE	Char	663	168	8	Date NPI4 becomes effective.
NPI4 END DATE	Char	671	176	8	Date NPI4 is terminated.
NPI5	Char	679	160	10	National Provider Identifier 5
NPI5 EFFECTIVE DATE	Char	689	170	8	Date NPI5 becomes effective.
NPI5 END DATE	Char	697	178	8	Date NPI5 is terminated.
NPI6	Char	705	714	10	National Provider Identifier 6
NPI6 EFFECTIVE DATE	Char	715	724	8	Date NPI6 becomes effective.
NPI6 END DATE	Char	723	730	8	Date NPI6 is terminated.
NPI7	Char	731	740	10	National Provider Identifier 7
NPI7 EFFECTIVE DATE	Char	741	748	8	Date NPI7 becomes effective.
NPI7 END DATE	Char	749	756	8	Date NPI7 is terminated.
NPI8	Char	757	766	10	National Provider Identifier 8
NPI8 EFFECTIVE DATE	Char	767	774	8	Date NPI8 becomes effective.
NPI8 END DATE	Char	775	782	8	Date NPI8 is terminated.
NPI9	Char	783	792	10	National Provider Identifier 9

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NPI9 EFFECTIVE DATE	Char	793	800	8	Date NPI9 becomes effective.
NPI9 END DATE	Char	801	808	8	Date NPI9 is terminated.
NPI10	Char	809	818	10	National Provider Identifier 10
NPI10 EFFECTIVE DATE	Char	819	826	8	Date NPI10 becomes effective.
NPI10 END DATE	Char	827	834	8	Date NPI10 is terminated.
NPI11	Char	835	844	10	National Provider Identifier 11
NPI11 EFFECTIVE DATE	Char	845	852	8	Date NPI11 becomes effective.
NPI11 END DATE	Char	853	860	8	Date NPI11 is terminated.
NPI12	Char	861	870	10	National Provider Identifier 12
NPI12 EFFECTIVE DATE	Char	871	878	8	Date NPI12 becomes effective.
NPI12 END DATE	Char	879	886	8	Date NPI12 is terminated.
NPI13	Char	887	896	10	National Provider Identifier 13
NPI13 EFFECTIVE DATE	Char	897	904	8	Date NPI13 becomes effective.
NPI13 END DATE	Char	905	912	8	Date NPI13 is terminated.
NPI14	Char	913	922	10	National Provider Identifier 14
NPI14 EFFECTIVE DATE	Char	923	930	8	Date NPI14 becomes effective.
NPI14 END DATE	Char	931	938	8	Date NPI14 is terminated.
NPI15	Char	939	948	10	National Provider Identifier 15
NPI15 EFFECTIVE DATE	Char	949	956	8	Date NPI15 becomes effective.
NPI15 END DATE	Char	957	964	8	Date NPI15 is terminated.
NPI16	Char	965	974	10	National Provider Identifier 16
NPI16 EFFECTIVE DATE	Char	975	982	8	Date NPI16 becomes effective.
NPI16 END DATE	Char	983	990	8	Date NPI16 is terminated.
NPI17	Char	991	1000	10	National Provider Identifier 17

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NPI17 EFFECTIVE DATE	Char	1001	1008	8	Date NPI17 becomes effective.
NPI17 END DATE	Char	1009	1016	8	Date NPI17 is terminated.
NPI18	Char	1017	1026	10	National Provider Identifier 18
NPI18 EFFECTIVE DATE	Char	1027	1034	8	Date NPI18 becomes effective.
NPI18 END DATE	Char	1035	1042	8	Date NPI18 is terminated.
NPI19	Char	1043	1052	10	National Provider Identifier 19
NPI19 EFFECTIVE DATE	Char	1053	1060	8	Date NPI19 becomes effective.
NPI19 END DATE	Char	1061	1068	8	Date NPI19 is terminated.
NPI20	Char	1069	1078	10	National Provider Identifier 20
NPI20 EFFECTIVE DATE	Char	1079	1086	8	Date NPI20 becomes effective.
NPI20 END DATE	Char	1087	1094	8	Date NPI20 is terminated.
NPI21	Char	1095	1104	10	National Provider Identifier 21
NPI21 EFFECTIVE DATE	Char	1105	1112	8	Date NPI21 becomes effective.
NPI21 END DATE	Char	1113	1120	8	Date NPI21 is terminated.
NPI22	Char	1121	1130	10	National Provider Identifier 22
NPI22 EFFECTIVE DATE	Char	1131	1138	8	Date NPI22 becomes effective.
NPI22 END DATE	Char	1139	1146	8	Date NPI22 is terminated.
NPI23	Char	1147	1156	10	National Provider Identifier 23
NPI23 EFFECTIVE DATE	Char	1157	1164	8	Date NPI23 becomes effective.
NPI23 END DATE	Char	1165	1172	8	Date NPI23 is terminated.
NPI24	Char	1173	1182	10	National Provider Identifier 24
NPI24 EFFECTIVE DATE	Char	1183	1190	8	Date NPI24 becomes effective.
NPI24 END DATE	Char	1191	1198	8	Date NPI24 is terminated.

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NPI25	Char	1199	1208	10	National Provider Identifier 25
NPI25 EFFECTIVE DATE	Char	1209	1216	8	Date NPI25 becomes effective.
NPI25 END DATE	Char	1217	1224	8	Date NPI25 is terminated.
NPI26	Char	1225	1234	10	National Provider Identifier 26
NPI26 EFFECTIVE DATE	Char	1235	1242	8	Date NPI26 becomes effective.
NPI26 END DATE	Char	1243	1250	8	Date NPI26 is terminated.
NPI27	Char	1251	1260	10	National Provider Identifier 27
NPI27 EFFECTIVE DATE	Char	1261	1268	8	Date NPI27 becomes effective.
NPI27 END DATE	Char	1269	1276	8	Date NPI27 is terminated.
NPI28	Char	1277	1286	10	National Provider Identifier 28
NPI28 EFFECTIVE DATE	Char	1287	1294	8	Date NPI28 becomes effective.
NPI28 END DATE	Char	1295	1303	8	Date NPI28 is terminated.
NPI29	Char	1303	1312	10	National Provider Identifier 29
NPI29 EFFECTIVE DATE	Char	1313	1320	8	Date NPI29 becomes effective.
NPI29 END DATE	Char	1321	1328	8	Date NPI29 is terminated.
NPI30	Char	1329	1338	10	National Provider Identifier 30
NPI30 EFFECTIVE DATE	Char	1339	1346	8	Date NPI30 becomes effective.
NPI30 END DATE	Char	1347	1354	8	Date NPI30 is terminated.
FILLER	Char	1355	1454	100	For future expansion. Field filled with all spaces.
NEWLINE	Char	1455	1455	1	Newline character = 0x0a

Trailer Record

Field	Data Type	Start	End	Length	Description

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RECORD ID	Char	1	2	2	Value ‘TT’ to denote trailer record
DETAIL RECORDS	Number	3	11	9	Total number of detail records in the file.
TOTAL RECORDS	Number	12	20	9	Total number of records (including header and trailer) in the file.
NEWLINE	Char	21	21	1	Newline character = 0x0a

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APPENDIX M. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM (EPSDT)

Periodicity Schedule

Infancy
-- < 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
-- 8 years
-- 10 years

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

Required Components - Initial and Periodic Health Assessments

Health History:

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Complete History

I

nitial 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

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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)

I

mmediately
Cholesterol Screening — *According to recommended medical standards (AAP1)

Sickle Cell Screening

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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)

Immunizations: Cont.
HiB
MMR
Varicella
Td
PPD

Health Education/ Anticipatory Guidance
(Age Appropriate)

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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

Special Services

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

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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.

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APPENDIX N. PROGRAM INTEGRITY REQUIREMENTS

I. ORGANIZATION

The Contractor shall establish a Program Integrity Unit (PIU) to identify Fraud, Waste and Abuse and refer to the Department any suspected Fraud or Abuse of Members and Providers. The Program Integrity Unit (PIU) shall be organized so that:

(a) Required Fraud, Waste and Abuse activities are conducted by staff with separate authority to direct PIU activities and functions specified in this Appendix on a continuous and on-going basis;

(b) Written policies, procedures, and standards of conduct demonstrate the organization's commitment to comply with all applicable contract requirements and standards and federal and state laws, regulations and standards;

(c) The unit establishes, controls, evaluates and revises Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure compliance with all applicable contract requirements and standards and Federal and State laws, regulations and requirements;

(d) The staff consists of a compliance officer in addition to auditing and clinical staff;

(e) The unit prioritizes 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:

(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries,
(2) High dollar amount of potential overpayment, or
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern;

(f) Ongoing education is provided to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives;

(g) Contractor attends any training given by the Commonwealth/Fiscal Agent, its designees, or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training; and

(h) There are a minimum of two (2) full-time investigators:

(1)

With a minimum of three (3) years of Medicaid fraud, waste and abuse investigatory experience

(2)

Located in Kentucky; and

(3)

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Dedicated 100% to the Kentucky Medicaid Program.

II. FUNCTION

Contractor and/or Contractor's PIU, shall:

(a) Prevent Fraud, Waste and Abuse by identifying vulnerabilities in the Contractor's program including identification of Member and Provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following:

(1) Recovery of overpayments,
(2) Changes to policy,
(3) Dispute resolution meetings, and
(4) Appeals;

(b) Proactively detect incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithms, investigations and record reviews;

(c) Determine the factual basis of allegations concerning Fraud or Abuse made by Members, Providers and other sources;

(d) Initiate appropriate administrative actions to collect overpayments adhering to state requirements;

(e) At the closure of an initial investigation:

(1) Upon finding a factual basis for potential Fraud, Waste, or Abuse, refer to the Department for possible civil and/or criminal prosecution, and administrative sanctions; or

(2) Upon finding no factual basis for the potential of Fraud, Waste or Abuse, request and receive the Department's written permission to administratively collect overpayments in excess of $500; or

(3) Upon finding no factual basis for potential Fraud, Waste, or Abuse, or overpayment, request and receive the Department's written permission to close the investigation without further action of the Contractor and/or Contractor's PIU.

(f) Initiate and maintain network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside groups;

(g) Make and receive recommendations to enhance the ability of the Parties to prevent, detect and deter Fraud, Waste or Abuse;

(h) Provide for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;

(i) Provide for internal monitoring and auditing of Contractor and its subcontractors; and supply the Department with reports on a quarterly or as-requested basis on its activity or ad hoc as necessary;

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(j) Be subject to on-site reviews; and fully comply with requests from the Department to supply documentation and records;

(k) Collect outstanding debt owed to the Department from members or providers; and provide monthly reports of activity and collections to the Department;

(l) Allow the Department to collect and retain any overpayments if the Contractor has not taken appropriate action to collect the overpayment after one hundred and eighty (180) days;

(m) The Contractor shall, as requested by the Department, remit the amount of provider overpayments not identified by the contractor within ninety (90) calendar days of notification by the Department unless otherwise notified in writing by the Department or its contracted entity;

(n) 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;

(o) Conduct regular post-payment audits of Provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Department;

(p) Conduct on-site and desk audits of Providers and report the results including identified overpayments and recommendations to the Department;

(q) Locally maintain 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;

(r) Designate a contact person to work with staff, investigators and attorneys from the Department, OIG and any other agent or contractor of the Department;

(s) Ensure the integrity of PIU referrals to the Department and shall not subject referrals to the approval of the Contractor's management or officials;

(t) Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with a Member whether the services billed by Provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;

(u) Run algorithms on billed claims data over a time span sufficient to identify potential fraudulent billing patterns and develop a process and report quarterly or as otherwise requested to the Department all algorithms, issues identified, actions taken to address those issues and the overpayments collected;

(v) Collect administratively from Members for overpayments that were declined prosecution for Medicaid Program Violations (MPV);

(w) Comply with the program integrity requirements set forth in the Patient Protection and Affordable Care Act, specifically 42 CFR 438.608, and all applicable requirements and standards under this contract and any federal and state laws and regulations, and provide policies and procedures to the Department for review and approval;

(x) Report to the Department any Provider denied enrollment by Contractor for any

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reason, including those contained in 42 CFR 455.106, within 5 days of the enrollment denial;

(y) Recover overpayments from Providers;

(z) Identify Providers for pre-payment review as a result of the Provider's activities in accordance with the contract;

(aa) Conduct a minimum of three (3) on-site visits per quarter related to investigations of suspected fraud and abuse. The site visit shall be approved within a minimum of ten (10) calendar days by the Department;

(bb) Notify the Department if there is an absence or vacancy in an investigator position that is longer than thirty (30) days, and include a contingency plan to remain compliant with the contract requirements in the interim; and

(cc) Correct any weaknesses, deficiencies, or noncompliance items identified as a result of a review or audit conducted by the Department, CMS, or by any other State or Federal Agency or agents thereof that has oversight of the Medicaid program. Corrective action shall be completed the earlier of thirty (30) calendar days or the timeframes established by Federal and state laws and regulations.

III. PATIENT ABUSE/MEMBER SAFETY

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 with copy to the Department and OIG. Potential Member safety issues related to investigations shall be reported in accordance with state law with a copy to the Department's Program Integrity Division Director and Program Quality & Outcomes Division Director.

IV. COMPLAINT SYSTEM

The Contractor's PIU shall have an operational system to receive, investigate and track the status of Fraud, Waste and Abuse complaints from Members, Providers and all other sources which may be made against the Contractor, Providers or Members. The system shall contain the following:

(a) Upon receipt of a complaint or other indication of potential Fraud or Abuse, the Contractor's PIU shall conduct an initial investigation to determine the validity of the complaint;

(b) The PIU should review background information and MIS data; however, the initial investigation shall not include interviews with the subject concerning the alleged instance of Fraud or Abuse;

(c) If the initial investigation results in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to the Department; however, the PIU shall take whatever remedial actions may be necessary, up to and including administrative recovery of identified

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overpayments of $500 or less;

(d) If the initial investigation results in a reasonable belief that Fraud or Abuse has occurred, the PIU shall refer the case and all supporting documentation to the Department;

(e) The Department will review the referral and attached documentation, make a determination and notify the PIU as to whether the OIG will investigate the case or return it to the PIU for appropriate administrative action;

(f) If, in the process of conducting an initial 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 of their findings and proceed only in accordance with instructions received from the Department;

(g) If the Department determines that it will refer a case referred by the PIU to the OIG, the OIG will conduct a preliminary investigation, review the PIU's report and evidence, gather additional evidence if needed, and forward information, if warranted, to the Attorney General's Medicaid Fraud Control Unit, for appropriate action;

(h) If the OIG opens an investigation based on a complaint received from a source other than the Contractor, the OIG will, upon completion of the preliminary investigation, provide a copy of the investigative report to the Department, the PIU, or if warranted, to MFCU, for appropriate actions;

(i) If the OIG investigation results in a referral to the MFCU and/or the U.S. Attorney, the OIG will notify the Department and the PIU of the referral. The Department and the PIU shall only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;

(j) Upon approval of the Department, Contractor shall suspend and escrow 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;

(k) Upon completion of the PIU's initial investigation, the PIU shall provide the Department a copy of their investigative report, which shall contain the following elements:

(1) Name and address of subject;
(2) Medicaid identification number;
(3) Source of complaint;
(4) State the complaint/allegation;
(5) Date assigned to the investigator;
(6) Name of investigator;
(7) Date of completion;
(8) Detail as to what timeframe was reviewed;
(9) How many member records were reviewed for that timeframe and the total of number of claims;
(10) The issues identified;
(11) Methodology used during investigation;

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(12) Facts discovered by the investigation as well as the initial case report and supporting documentation;
(13) Attach all exhibits or supporting documentation;
(14) Include recommendations as considered necessary, for administrative action or policy revision;
(15) Identify overpayment, if any, and include recommendation concerning collection;
(16) Reason for closure of the report, if applicable;
(17) Request to send as a referral for a preliminary investigation for a credible allegation of fraud, if applicable; and
(13) Any other elements identified by CMS for fraud referral;

(l) The Contractor's PIU shall provide the Department a quarterly Member and Provider status report of all cases including actions taken in adherence with state requirements, or case information shall be made available to the Department upon request;

(m) The Contractor's PIU shall maintain access to a formal case tracking and case management system, which can report the status of a particular complaint or grievance process or the status of a specific identified overpayment or recoupment; and

(n) The Contractor's PIU shall assure a Grievance and Appeal process for Members and Providers in accordance with 907 KAR 1:671.

V. CASE TRACKING AND CASE MANAGEMENT

(a) The Contactor shall have a case tracking and case management system to track member and provider cases;

(b) The Contractor shall have the ability to query for ad hoc reporting or case status through the case tracking system for any period of time and shall be able to report the following for provider cases:

(1) PIU Case number,
(2) Provider name,
(3) Provider number,
(4) NPI (if applicable),
(6) Source of Complaint,
(7) OIG Referral Number (if applicable),
(8) MAT Case Y/N (if applicable to report),
(9) Date complaint received by Contractor,
(10) Date opened,
(11) Name of PIU investigator assigned,
(12) Summary of Complaint,
(13) Justification that a referral for a preliminary investigation was not warranted based upon the evidence in the case file,
(14) PIU action(s) taken and date(s),
(15) Amount of overpayment if any (please note potential overpayments of $500 or more should be referred for preliminary investigation),

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(16) Administrative actions (if any) or referral with description, and
(17) Closure Date* (if applicable) of initial investigation with approval from supervisor. Supervisor approval should demonstrate/attest verification of each component in the case file.

(c) The Contractor shall have the ability to query for ad hoc reporting or case status through the case tracking system for any period of time and shall be able to report the following for member cases:

(1) PIU Case number,
(2) Member name,
(3) Member number,
(4) Date of Birth (if known),
(5) Social Security Number (if known),
(6) Source of Complaint,
(7) OIG Referral Number (if applicable),
(8) Date complaint received by Contractor,
(9) Date opened,
(10) Name of PIU investigator assigned,
(11) Summary of Complaint,
(12) Justification that a preliminary investigation was not warranted based upon the evidence in the case file,
(13) PIU action(s) taken and date(s) within the ten (10) day review period,
(14) Amount of overpayment if any,
(15) Administrative actions (if any) or referral with description,
(16) Closure Date* (if applicable) of initial investigation with approval from supervisor. Supervisor approval should demonstrate/attest verification of each component in the case file.

VI. REPORTING

(a) The Contractor's PIU shall report on a monthly basis provider internal referrals (tips) and the disposition of the prior month's internal referrals, and on a quarterly basis, as required by the Department, all activities and processes for each investigative case for that quarter to the Department. The Contractor shall have the ability to report all aspects of a member or provider file from opening to closure upon request, including overpayments identified, overpayment adjusted and recoupments of overpayments;

(b) If any employee or subcontractor employee of the Contractor discovers or is made aware of an incident of possible Member or Provider Fraud, Waste or

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Abuse, the incident shall be immediately reported to the PIU Coordinator;

(c) The Contractor's PIU shall immediately report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members, Providers or employees to the Department in adherence to state requirements;

(d) The Contractor shall adhere to all ad hoc reporting requests whether one time or recurring in accordance with Section 38.1 of this contract;

(e) The Contractor shall report all overpayments identified as prescribed by the Department;

(f) The Contractor shall report the collection of provider overpayments and prepayment cost avoidance in relation to the quarterly total of Monthly Benefit Payments;

(g) The Contractor shall report the escrow of provider payments in adherence to state requirements;

(h) The Contractor shall report site visits conducted in adherence to state requirements; and

(d) The Contractor is required to report the following data elements to the Department on a quarterly basis, in an excel format:

(1) PIU Case number;
(2) Provider /Member name;
(3) Provider Medicaid ID/Member Medicaid number;
(5) Date complaint received by Contractor;
(6) Provider NPI (if nonmember case);
(7) Source of complaint,
(8) OIG Case Number;
(9) Date complaint or referral received;
(10) Date case opened;
(11) MAT related (Y or N);
(12) Summary of Complaint with timeframe reviewed;
(13) Initial investigation (Y or N);
(14) Actions taken with date(s);
(15) Referred to DMS (with appropriate code);
(16) Date referred to DMS (if applicable);
(17) Provider on prepayment (Y or N);
(18) Overpayment identified, and
(19) Date case closed (if applicable).

VII.

AVAILABILITY AND ACCESS TO DATA

The Contractor shall:

(a) Gather, produce, and maintain records including, but not limited to, ownership disclosure, for all Providers and subcontractors, submissions, applications,

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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;

(b) Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department, the OIG and any other agent or contractor of the Department;

(c) Backup, store and be able to recreate reported data upon demand for the Department, the OIG and any other agent or contractor of the Department;

(d) Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department, the OIG, any other agent or contractor of the Department or other authorized federal or state agency; and, shall provide access to Contractor 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;

(e) Produce records in electronic format for review and manipulation by the Department, the OIG and any other agent or contractor of the Department;

(f) Allow designated Department staff, the OIG, and any other agent or contractor of the Department read access to ALL data in the Contractor's MIS systems;

(g) Provide Contractor's PIU access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract;

(h) Fully cooperate with the Department, the OIG, any other agent or contractor of the Department, the United States Attorney's Office and other law enforcement agencies in the investigation of Fraud or Abuse cases; and

(i) Provide identity and cover documents and information for law enforcement investigators under cover.

APPENDIX O. PAID CLAIMS LISTING REQUIREMENTS

Hospitals:

1. The Contractor shall supply a paid claims listing to each contracted Hospital and to the Department for Medicaid Services (the Department) for each contracted hospital within sixty (60) days of the last day of the Hospital's fiscal year end date and a second set of data fourteen (14) months after the Hospital's fiscal year end date. The paid claims listing shall be in a format as required by the Department. The paid claims listing shall include all claims with discharge dates within the Hospital's fiscal year that are paid from the first day of the Hospital's fiscal year to ninety

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(90) days after the end of the Hospital's fiscal year. For all hospitals, the MCO shall provide separate reports for adjudicated claims associated with both inpatient services and outpatient services provided to eligible Members.

2. The Contractor shall supply a summary of payments outside claims payments. The summary should illustrate the amount of the payment, its purpose and its application to Inpatient or Outpatient services, reported for the hospital fiscal year end.

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

Upon request the Contractor shall supply a paid claims listing to each contracted FQHC or RHC to the Department for Medicaid Services (the Department) within ninety (90) days of the last day of the state fiscal year. The paid claims listing shall include all claims with dates for service falling within the state fiscal year that are paid within the same fiscal year.

NOTE: The vendor shall provide paid claims listing reports for other program areas as needed.

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APPENDIX P. MCO CAPITATION RECONCILIATION INBOUND/OUTBOUND FILE LAYOUTS

There are two (2) capitation reconciliation file types with an inbound and outbound file for each.

> 'Report 230': Contains all Members and capitation months that the MCO identifies for which a capitation payment has not been received.
>
> 'Report 250': Contains all Members and capitation months for which the MCO believes an inaccurate capitation payment was made. This file is to also include potential duplicate capitation payments.

Format: Inbound and outbound files to use semi-colon delimited text.

Naming Convention:

Where XX is the MCO two character designation

> Inbound (MCO to CHFS):
> XX_Reports_YYMMDD_Report230
>
> XX_Reports_YYMMDD_Report250
>
> Outbound (CHFS to MCO):
> CHFS_XX_YYMMDD_Report230
>
> CHFS_XX_YYMMDD_Report250

File Transmission: Move-IT

Frequency:

> MCO to submit the Inbound files once per month.
>
> CHFS to provide the Outbound files, under normal circumstances, on the Monday following the MCO Inbound submission.

<u>Inbound File Layout for 'Report 230'</u>

Field	Data Type	Format	Comments
MCO_ID	Char(10)		MCO Medicaid ID
MEDICAID_ID	Char(12)		Member Medicaid ID that the MCO is requesting payment for
CAP_MONTH	int (6)	YYYYMM	Month that the MCO is requesting

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			payment for
AMT_EXPECTED	Decimal(8,2)		Cap payment amount the MCO is expecting

Inbound File Layout for 'Report 250'

Field	Data Type	Format	Comments
MCO_ID	Char(10)		MCO Medicaid ID
ADJUST_CDE	Char(2)		Type of adjustment for the record
CAP_MONTH	int (6)	YYYYMM	Month that the MCO received an incorrect payment
MEDICAID_ID	Char(12)		Member Medicaid ID that the MCO received a payment for
PD_AMT	Decimal (8,2)		Cap payment amount the MCO received
AMT_EXPECTED	Decimal (8,2)		Cap payment amount the MCO is expecting

Outbound File Layout for 'Report 230'

Field	Data Type	Format	Comments
MEDICAID_ID	Char(12)		Data from MCO Inbound file to be returned
CAP_MONTH	int (6)	YYYYMM	Data from MCO Inbound file to be returned
RECON_DTE	Int (8)	YYYYMMDD	Date MCO transaction was processed for reconciliation
SAK_CAPITATION_PD	Int (9)		Cap Payment Unique Identifier: provided when cap already paid
FIN_DTE_PD	Int (8)	YYYYMMDD	MMIS Financial Paid Date: provided when cap already paid
AMT_PD	Decimal(8,2)		Cap Amount Paid: provided when cap already paid
MEDICAID_ID_PD	Char(12)		Medicaid ID that the Cap Was Paid Under: provided when cap already paid
MESSAGE_CDE	Char(4)		Code value for the message being returned
MESSAGE	Varchar(255)		Findings based on current active MMIS data

Outbound File Layout for 'Report 250'

Field	Data Type	Format	Comments
CAP_MONTH	int (6)	YYYYMM	Data from MCO Inbound file to be returned

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MEDICAID_ID	Char(12)		Data from MCO Inbound file to be returned
RECON_DTE	Int (8)	YYYYMMDD	Date MCO transaction was processed for reconciliation
MESSAGE_CDE	Char(4)		Code value for the message being returned
MESSAGE	Varchar(255)		Findings based on current active MMIS data

Valid values for the ADJUST_CDE in the Inbound 'Report 250'

ADJUST_CDE	COMMENT
OP	Overpayment: MCO believes the capitation payment received was too high because the member qualifies under a different Category of Aid and/or resides in a different region.
UP	Underpayment: MCO believes the capitation payment received was too low because the member qualifies under a different Category of Aid and/or resides in a different region.
PR	Prorate: MCO believes the capitation payment received was incorrectly prorated based on the Member's Effective date and/or Category of Aid

Valid Values for MESSAGE_CDE and MESSAGE in the Outbound 'Report 230' and Outbound 'Report 250'

MESSAGE_CDE	MESSAGE	Report
M_01	MEMBER NOT MEDICAID ELIGIBLE DURING CAP MONTH	All
M_02	MEMBER NOT ASSIGNED TO MCO DURING CAP MONTH	All
M_03	RECORD REPORTED TO DMS MEMBER SERVICES FOR ADDITIONAL RESEARCH	All
M_04	CAPITATION PAYMENT WAS PAID FOR CAP MONTH	230
M_05	CURRENT DATA SHOWS CAP PAYMENT FOR CAP MONTH WILL BE PAID DURING NEXT RECON	230
M_06	CURRENT DATA SHOWS PAID AMOUNT WAS CORRECT	250
M_07	CURRENT DATA SHOWS PAID AMOUNT WAS AN OVERPAYMENT	250
M_08	CURRENT DATA SHOWS PAID AMOUNT WAS AN UNDERPAYMENT	250
M_09	CURRENT DATA SHOWS PAID AMOUNT WAS NOT PRORATED CORRECTLY	250
M_10	MMIS DATA DOES NOT INDICATE THE PAYMENTS ARE DUPLICATE	250
M_11	MMIS DATA INDICATES THE PAYMENTS ARE DUPLICATE - RESEARCH ITEM OPENED	250
M_12	MEMBER MEDICAID ID IS INVALID	All

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CONTINUATION CERTIFICATE

Travelers Casualty and Surety Company of America , Surety upon

a certain Bond No. 106325876

dated effective July 1, 2015
(MONTH-DAY-YEAR)

on behalf of Aetna Better Health of Kentucky Insurance Company -
(PRINCIPAL)

and in favor of State of Kentucky, Finance and Administration Cabinet

(OBLIGEE)

does hereby continue said bond in force for the further period

beginning on June 30, 2019
(MONTH-DAY-YEAR)

and ending on June 30, 2020
(MONTH-DAY-YEAR)

Amount of bond $25,000,000.00

Description of bond Service Ks - Other Annual Performance Bond - Cabinet for Health and Family Services (CHFS), Dept of Medicaid Services, Medicaid Managed Care (all regions) RFP 758 1500000283

PROVIDED: That this continuation certificate does not create a new obligation and is executed upon the express condition and provision that the Surety's liability under said bond and this and all Continuation Certificates issued in connection therewith shall not be cumulative and that the said Surety's aggregate liability under said bond and this and all such Continuation Certificates on account of all defaults committed during the period (regardless of the number of years) said bond had been and shall be in force, shall not in any event exceed the amount of said bond as hereinbefore set forth.

Signed and dated on May 9, 2019
(MONTH-DAY-YEAR)

Travelers Casualty and Surety Company of America

By April D. Perez

April D. Perez, Attorney-in-Fact

S-0157/GEEF 11/99

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TRAVELERS

Travelers Casualty and Surety Company of America
Travelers Casualty and Surety Company
St. Paul Fire and Marine Insurance Company

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS: That Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company are corporations duly organized under the laws of the State of Connecticut (herein collectively called the "Companies"), and that the Companies do hereby make, constitute and appoint April D. Perez, of Morristown, New Jersey, their true and lawful Attorney-in-Fact to sign, execute, seal and acknowledge any and all bonds, recognizances, conditional undertakings and other writings obligatory in the nature thereof on behalf of the Companies in their business of guaranteeing the fidelity of persons, guaranteeing the performance of contracts and executing or guaranteeing bonds and undertakings required or permitted in any actions or proceedings allowed by law.

IN WITNESS WHEREOF, the Companies have caused this instrument to be signed, and their corporate seals to be hereto affixed, this **3rd** day of **February, 2017.**

HARTFORD, CONN. — TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA

HARTFORD, CONN. — TRAVELERS CASUALTY AND SURETY COMPANY

CORPORATE SEAL — ST. PAUL FIRE AND MARINE INSURANCE COMPANY

State of Connecticut

City of Hartford ss.

By: _____
Robert L. Raney, Senior Vice President

On this the **3rd** day of **February, 2017**, before me personally appeared **Robert L. Raney**, who acknowledged himself to be the Senior Vice President of Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company, and that he, as such, being authorized so to do, executed the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

In Witness Whereof, I hereunto set my hand and official seal.

My Commission expires the **30th** day of **June, 2021**

MARIE C. TETREAULT NOTARY PUBLIC CONNECTICUT

Marie C Tetreault
Marie C. Tetreault, Notary Public

This Power of Attorney is granted under and by the authority of the following resolutions adopted by the Boards of Directors of Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company, which resolutions are now in full force and effect, reading as follows:

RESOLVED, that the Chairman, the President, any Vice Chairman, any Executive Vice President, any Senior Vice President, any Vice President, any Second Vice President, the Treasurer, any Assistant Treasurer, the Corporate Secretary or any Assistant Secretary may appoint Attorneys-in-Fact and Agents to act for and on behalf of the Company and may give such appointee such authority as his or her certificate of authority may prescribe to sign with the Company's name and seal with the Company's seal bonds, recognizances, contracts of indemnity, and other writings obligatory in the nature of a bond, recognizance, or conditional undertaking, and any of said officers or the Board of Directors at any time may remove any such appointee and revoke the power given him or her; and it is

FURTHER RESOLVED, that the Chairman, the President, any Vice Chairman, any Executive Vice President, any Senior Vice President or any Vice President may delegate all or any part of the foregoing authority to one or more officers or employees of this Company, provided that each such delegation is in writing and a copy thereof is filed in the office of the Secretary; and it is

FURTHER RESOLVED, that any bond, recognizance, contract of indemnity, or writing obligatory in the nature of a bond, recognizance, or conditional undertaking shall be valid and binding upon the Company when (a) signed by the President, any Vice Chairman, any Executive Vice President, any Senior Vice President or any Vice President, any Second Vice President, the Treasurer, any Assistant Treasurer, the Corporate Secretary or any Assistant Secretary and duly attested and sealed with the Company's seal by a Secretary or Assistant Secretary; or (b) duly executed (under seal, if required) by one or more Attorneys-in-Fact and Agents pursuant to the power prescribed in his or her certificate or their certificates of authority or by one or more Company officers pursuant to a written delegation of authority; and it is

FURTHER RESOLVED, that the signature of each of the following officers: President, any Executive Vice President, any Senior Vice President, any Vice President, any Assistant Vice President, any Secretary, any Assistant Secretary, and the seal of the Company may be affixed by facsimile to any Power of Attorney or to any certificate relating thereto appointing Resident Vice Presidents, Resident Assistant Secretaries or Attorneys-in-Fact for purposes only of executing and attesting bonds and undertakings and other writings obligatory in the nature thereof, and any such Power of Attorney or certificate bearing such facsimile signature or facsimile seal shall be valid and binding upon the Company and any such power so executed and certified by such facsimile signature and facsimile seal shall be valid and binding on the Company in the future with respect to any bond or understanding to which it is attached.

I, **Kevin E. Hughes**, the undersigned, Assistant Secretary of Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company, do hereby certify that the above and foregoing is a true and correct copy of the Power of Attorney executed by said Companies, which remains in full force and effect.

Dated this 9th day of May, 2019.

HARTFORD, CONN. — TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA

HARTFORD, CONN. — TRAVELERS CASUALTY AND SURETY COMPANY

CORPORATE SEAL — ST. PAUL FIRE AND MARINE INSURANCE COMPANY

Kevin E. Hughes
Kevin E. Hughes, Assistant Secretary

To verify the authenticity of this Power of Attorney, please call us at 1-800-421-3880.
Please refer to the above-named Attorney-in-Fact and the details of the bond to which the power is attached.

Marsh

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TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA

HARTFORD, CONNECTICUT 06183

FINANCIAL STATEMENT AS OF DECEMBER 31, 2018

CAPITAL STOCK $ 6,480,000

ASSETS		LIABILITIES & SURPLUS	
CASH AND INVESTED CASH	$ 36,728,596	UNEARNED PREMIUMS	$ 979,007,378
BONDS	3,507,432,239	LOSSES	750,995,504
STOCKS	294,199,598	LOSS ADJUSTMENT EXPENSES	166,673,871
INVESTMENT INCOME DUE AND ACCRUED	36,287,129	COMMISSIONS	45,868,584
OTHER INVESTED ASSETS	3,507,839	TAXES, LICENSES AND FEES	14,584,663
PREMIUM BALANCES	250,478,792	OTHER EXPENSES	43,858,534
NET DEFERRED TAX ASSET	46,781,239	CURRENT FEDERAL AND FOREIGN INCOME TAXES	10,143,037
REINSURANCE RECOVERABLE	29,278,755	REMITTANCES AND ITEMS NOT ALLOCATED	21,277,153
SECURITIES LENDING REINVESTED COLLATERAL ASSETS	14,277,262	AMOUNTS WITHHELD / RETAINED BY COMPANY FOR OTHERS	30,289,553
RECEIVABLES FROM PARENT, SUBSIDIARIES AND AFFILIATES	27,813,266	RETROACTIVE REINSURANCE RESERVE ASSUMED	810,360
ASSUMED REINSURANCE RECEIVABLE AND PAYABLE	626,488	POLICYHOLDER DIVIDENDS	10,410,755
OTHER ASSETS	4,936,229	PROVISION FOR REINSURANCE	7,641,356
		ADVANCE PREMIUM	1,608,777
		REINSURANCE PAYABLE ON PAID LOSSES & LOSS ADJ. EXPENSES	868,002
		PAYABLE FOR SECURITIES LENDING	14,277,262
		CEDED REINSURANCE NET PREMIUMS PAYABLE	46,469,976
		OTHER ACCRUED EXPENSES AND LIABILITIES	335,489
		TOTAL LIABILITIES	$ 2,145,120,254
		CAPITAL STOCK	$ 6,480,000
		PAID IN SURPLUS	433,803,760
		OTHER SURPLUS	1,670,943,418
		TOTAL SURPLUS TO POLICYHOLDERS	$ 2,111,227,178
TOTAL ASSETS	$ 4,256,347,432	TOTAL LIABILITIES & SURPLUS	$ 4,256,347,432

STATE OF CONNECTICUT)

COUNTY OF HARTFORD) SS.

CITY OF HARTFORD)

MICHAEL J. DOODY, BEING DULY SWORN, SAYS THAT HE IS SECOND VICE PRESIDENT, OF TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA, AND THAT TO THE BEST OF HIS KNOWLEDGE AND BELIEF, THE FOREGOING IS A TRUE AND CORRECT STATEMENT OF THE FINANCIAL CONDITION OF SAID COMPANY AS OF THE 31ST DAY OF DECEMBER, 2018.

Michael J. Doody

VICE PRESIDENT, FINANCE

SUBSCRIBED AND SWORN TO BEFORE ME THIS
28TH DAY OF MARCH, 2019

Susan M. Weissleder

NOTARY PUBLIC

SUSAN M. WEISSLEDER
Notary Public
My Commission Expires November 30, 2022

SUSAN M. WEISSLEDER NOTARY PUBLIC CONNECTICUT

HARTFORD CORP.

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Commonwealth of Kentucky
FINANCE AND ADMINISTRATION CABINET
Office of the Controller
Office of Procurement Services
Room 096 Capitol Annex
Frankfort, Kentucky 40601
(502) 564-4510
(502) 564-1434 Facsimile

MATTHEW G. BEVIN
Governor

William M. Landrum III
Secretary

Ed Ross
Executive Director

MASTER AGREEMENT RENEWAL

Today's Date: June 5, 2019	**MA Number: MA 758 160000004-1**
Buyer: Emy Womack (502-564-6515) emy.womack@ky.gov	**Agency: Medicaid Services Benefits** **Contact: Lindsay Jackson**
Service: Managed Care Services	**Vendor: Aetna Better Health of Ky. Assignee for Coventry Health** **Contact: Jonathon Copley** **Email: copleyj@aetna.com**

The above referenced Master Agreement expired, **June 30, 2019.** The terms of the contract allows for a one (1) year renewal through **June 30, 2020.** all parties (Commonwealth and Vendor) concurring, leaving zero (0) renewal options remaining on this contract. Please indicate your concurrence or refusal and fax the signed form to 502-564-1434, or scan and email to the buyer listed below.

Return this renewal form, the attached affidavit and any proposed changes to the contract, if applicable, immediately.

☒Yes, I agree to renew for the above period.
☐No, I do not wish to renew. (Please explain why)

If there are any questions, please contact the buyer listed below.

X David Delaney **David Delaney** **6/13/19** **DelaneyD2@aetna.com** **602-659-1214**
Signature (REQUIRED) Print/Typed Name Date email address Telephone Number

Vendors shall submit a signed and notarized affidavit before the renewal can be processed. Failure to submit may cause the Master Agreement to lapse.

Return to-
Buyer: Emy Womack
Phone: 502-564-6515
Email: emy.womack@ky.gov
Fax: 502-564-1434
Finance and Administration Cabinet
Office of Procurement Services
702 Capitol Avenue,
Frankfort, KY 40601

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Solicitation/Contract #: MA 758 160000004-1

Affidavit Effective Date: June 13, 2019
Affidavit Expiration Date: June 13, 2020
Maximum Length One-Year

REQUIRED AFFIDAVIT FOR BIDDERS, OFFERORS AND CONTRACTORS **PAGE 1 OF 2**

FOR BIDS AND CONTRACTS IN GENERAL:

I. Each bidder or offeror swears and affirms under penalty of perjury, that:

a. In accordance with KRS 45A.110 and KRS 45A.115, neither the bidder or offeror as defined in KRS 45A.070(6), nor the entity which he/she represents, has knowingly violated any provisions of the campaign finance laws of the Commonwealth of Kentucky; and the award of a contract to the bidder or offeror or the entity which he/she represents will not violate any provisions of the campaign finance laws of the Commonwealth.

b. The bidder or offeror swears and affirms under penalty of perjury that, to the extent required by Kentucky law, the entity bidding, and all subcontractors therein, are aware of the requirements and penalties outlined in KRS 45A.485; have properly disclosed all information required by this statute; and will continue to comply with such requirements for the duration of any contract awarded.

c. The bidder or offeror swears and affirms under penalty of perjury that, to the extent required by Kentucky law, the entity bidding, and its affiliates, are duly registered with the Kentucky Department of Revenue to collect and remit the sales and use tax imposed by KRS Chapter 139, and will remain registered for the duration of any contract awarded.

d. The bidder or offeror swears and affirms under penalty of perjury that the entity bidding is not delinquent on any state taxes or fees owed to the Commonwealth of Kentucky and will remain in good standing for the duration of any contract awarded.

FOR "NON-BID" CONTRACTS (I.E. SOLE-SOURCE; NOT-PRACTICAL OR FEASIBLE TO BID; OR EMERGENCY CONTRACTS, ETC):

II. Each contractor further swears and affirms under penalty of perjury, that:

a. In accordance with KRS 121.056, and if this is a non-bid contract, neither the contractor, nor any member of his/her immediate family having an interest of 10% or more in any business entity involved in the performance of any contract awarded, have contributed more than the amount specified in KRS 121.150 to the campaign of the gubernatorial slate elected in the election last preceding the date of contract award.

b. In accordance with KRS 121.330(1) and (2), and if this is a non-bid contract, neither the contractor, nor officers or employees of the contractor or any entity affiliated with the contractor, nor the spouses of officers or employees of the contractor or any entity affiliated with the contractor, have knowingly contributed more than $5,000 in aggregate to the campaign of a candidate elected in the election last preceding the date of contract award that has jurisdiction over this contract award.

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REQUIRED AFFIDAVIT FOR BIDDERS, OFFERORS AND CONTRACTORS **PAGE 2 OF 2**

c. In accordance with KRS 121.330(3) and (4), and if this is a non-bid contract, to the best of his/her knowledge, neither the contractor, nor any member of his/her immediate family, his/her employer, or his/her employees, or any entity affiliated with any of these entities or individuals, have directly solicited contributions in excess of $30,000 in the aggregate for the campaign of a candidate elected in the election last preceding the date of contract award that has jurisdiction over this contract.

As a duly authorized representative for the bidder, offeror, or contractor, I have fully informed myself regarding the accuracy of all statements made in this affidavit, and acknowledge that the Commonwealth is reasonably relying upon these statements, in making a decision for contract award and any failure to accurately disclose such information may result in contract termination, repayment of funds and other available remedies under law. If the bidder, offeror, or contractor becomes non-compliant with any statements during the affidavit effective period, I will notify the Finance and Administration Cabinet, Office of Procurement Services immediately. I understand that the Commonwealth retains the right to request an updated affidavit at any time.

David Delaney
Signature

David Delaney
Printed Name

Chief Financial Officer
Title

June 13, 2019
Date

Company Name: Aetna Better Health of Kentucky Insurance Company dba Aetna Better Heath of Kentucky

Address: 9900 Corporate Campus Drive
Ste 1000
Louisville, KY 40223

Subscribed and sworn to before me by David Delaney CFO
(Affiant) (Title)

of Aetna Better Health of KY (Company Name) this 13th day of June, 2019.

Newhouse
Notary Public

[seal of notary]

My commission expires: 2/8/2023

JANEEN NEWHOUSE
Notary Public, State of Arizona
Maricopa County
Commission # 557912
My Commission Expires
February 08, 2023