KENTUCKY SPIRIT HEALTH PLAN, INC.

APPENDICES

Table of Contents

A. Service Area

B. Approved Capitation Payment Rates

C. Management Information System Requirements

D. Encounter Data Submission Requirements

E. Encounter Data Submission Quality Standards

F. Third Party Liability/Coordination of Benefits Requirements

G. Network Provider File Layout Requirements

H. Credentialing Process Coversheet

I. Covered Services

J. Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule

K. Reporting Requirements

L. Reporting Deliverables

M. Program Integrity Requirements

N. Performance Improvement Projects

O. Health Outcomes, Indicators, Goals and Performance Measures

P. Business Associates Agreement

Q. Annual Contract Monitoring Tools

Appendix A
Commonwealth of Kentucky
Medicaid Managed Care Organization (MCO) Regions

Service Area - Statewide Excluding Region 3

MCO Region 1 (includes the following 12 counties)

Ballard
Caldwell
Calloway
Carlisle
Crittenden
Fulton
Graves
Hickman
Livingston
Lyon
Marshall
McCracken

MCO Region 2 (includes the following 12 counties)

Christian
Daviess
Hancock
Henderson
Hopkins
McLean
Muhlenberg
Ohio
Todd
Trigg
Union
Webster

MCO Region 4 (includes the following 20 counties)

Adair
Allen
Barren
Butler
Casey
Clinton
Cumberland

Appendix A
Commonwealth of Kentucky
Medicaid Managed Care Organization (MCO) Regions

Service Area - Statewide Excluding Region 3

MCO Region 4 (includes the following 20 counties) - Continued

Edmonson
Green
Hart
Logan
McCreary
Metcalfe
Monroe
Pulaski
Russell
Simpson
Taylor
Warren
Wayne

MCO Region 5 (includes the following 21 counties)

Anderson
Bourbon
Boyle
Clark
Estill
Fayette
Franklin
Garrard
Harrison
Jackson
Jessamine
Lincoln
Madison
Mercer
Montgomery
Nicholas
Owen
Powell
Rockcastle
Scott
Woodford

Appendix A
Commonwealth of Kentucky
Medicaid Managed Care Organization (MCO) Regions

Service Area - Statewide Excluding Region 3

MCO Region 6 (includes the following 6 counties)

Boone
Campbell
Gallatin
Grant
Kenton
Pendleton

MCO Region 7 (includes the following 14 counties)

Bath
Boyd
Bracken
Carter
Elliott
Fleming
Greenup
Lawrence
Lewis
Mason
Menifee
Morgan
Robertson
Rowan

MCO Region 8 (includes the following 19 counties)

Bell
Breathitt
Clay
Floyd
Harlan
Johnson
Knott
Knox
Laurel
Lee
Leslie

Appendix A
Commonwealth of Kentucky
Medicaid Managed Care Organization (MCO) Regions

Service Area - Statewide Excluding Region 3

MCO Region 8 (includes the following 19 counties) -Continued

Letcher
Magoffin
Martin
Owsley
Perry
Pike
Whitley
Wolfe

Appendix B

Approved Capitation Payment Rates

KENTUCKY SPIRIT HEALTH PLAN, INC.

YEAR 1 – OCTOBER 1, 2011 THROUGH JUNE 30, 2012

	Year 1							
Families and Children	1	2	3	4	5	6	7	8
Infant (age under 1)	334.27	340.06		359.14	410.37	326.33	424.66	423.84
Child (age 1 through 5)	116.34	101.92		127.97	136.43	104.09	129.66	152.86
Child (age 6 through 12)	131.86	145.97		167.99	156.31	132.57	150.34	166.17
Child (age 13 through 18) - Female	240.25	241.12		256.22	267.12	226.04	225.74	252.04
Child (age 13 through 18) - Male	191.51	229.54		216.59	217.04	173.79	159.56	176.74
Adult (age 19 through 24) - Female	533.82	472.16		488.70	543.15	496.16	492.31	496.91
Adult (age 19 through 24) - Male	172.19	144.61		188.96	200.27	193.71	191.73	168.83
Adult (age 25 through 39) - Female	467.48	413.27		444.40	491.07	467.91	418.49	421.54
Adult (age 25 through 39) - Male	433.27	305.40		347.15	358.48	351.86	271.89	296.02
Adult (age 40 or older) - Female	500.43	416.49		502.07	534.56	493.94	547.50	467.94
Adult (age 40 or older) - Male	568.50	512.55		465.82	599.82	594.67	473.15	416.09
SSI Adults without Medicare								
Adult (age 19 through 24) - Female	563.86	560.63		597.40	525.90	513.59	549.09	506.23
Adult (age 19 through 24) - Male	475.97	355.37		324.98	436.95	524.99	421.44	346.72
Adult (age 25 through 44) - Female	733.94	652.22		707.82	739.25	750.35	768.14	674.01
Adult (age 25 through 44) - Male	476.03	499.40		547.05	656.73	649.12	520.16	540.73
Adult (age 45 or older) - Female	890.57	935.36		895.65	960.19	948.33	926.40	924.77
Adult (age 45 or older) - Male	816.14	858.44		771.16	936.59	971.95	751.90	762.22
Waiver Option								
Dual Eligible								
All Ages - Female	116.96	141.58		143.93	161.41	157.46	156.32	163.33
All Ages - Male	104.85	120.30		126.91	134.50	150.14	141.21	140.34
SSI Children								
Infant (age under 1)	3,177.99	2,983.31		4,121.55	5,643.79	4,272.65	4,529.93	3,819.84
Child (age 1 through 5)	447.02	510.66		598.05	957.40	976.76	606.79	609.28
Child (age 6 through 18)	505.72	608.15		662.98	627.05	479.66	487.10	420.16
Foster Care								
Infant (age under 1)	771.05	460.03		714.09	1,500.06	633.34	1,080.50	1,961.72
Child (age 1 through 5)	221.07	251.18		242.08	334.45	215.85	268.19	276.24
Child (age 6 through 12)	404.25	521.39		510.44	464.97	336.59	404.02	402.02
Child (age 13 or older) - Female	484.55	702.52		784.14	861.75	700.02	572.29	839.60
Child (age 13 or older) - Male	918.60	934.73		709.02	688.57	703.20	560.55	697.03

Appendix B (cont.)

Approved Capitation Payment Rates

KENTUCKY SPIRIT HEALTH PLAN, INC.

YEAR 2 – JULY 1, 2012 THROUGH JUNE 30, 2013

	Year 2							
Families and Children	1	2	3	4	5	6	7	8
Infant (age under 1)	339.33	344.74		365.36	420.18	332.42	432.70	433.19
Child (age 1 through 5)	117.93	103.51		129.61	139.89	106.22	132.60	156.08
Child (age 6 through 12)	132.90	147.48		169.30	158.27	133.43	152.74	168.68
Child (age 13 through 18) - Female	243.68	244.59		258.57	271.49	228.96	229.46	256.14
Child (age 13 through 18) - Male	194.60	234.50		219.51	221.38	176.55	161.98	179.33
Adult (age 19 through 24) - Female	538.87	476.29		494.45	549.52	501.68	498.29	503.71
Adult (age 19 through 24) - Male	173.25	146.24		191.17	202.59	196.71	192.96	170.63
Adult (age 25 through 39) - Female	470.74	415.64		447.67	495.72	471.98	422.78	425.00
Adult (age 25 through 39) - Male	434.80	306.11		349.05	361.42	354.76	274.50	297.35
Adult (age 40 or older) - Female	501.14	416.45		500.65	535.95	493.92	549.81	466.95
Adult (age 40 or older) - Male	570.33	512.79		465.56	599.29	590.01	473.30	414.96
SSI Adults without Medicare								
Adult (age 19 through 24) - Female	575.36	569.96		604.81	533.45	524.57	556.84	513.98
Adult (age 19 through 24) - Male	482.00	358.50		328.12	443.77	513.99	426.96	349.91
Adult (age 25 through 44) - Female	741.02	658.67		713.62	747.48	758.92	777.22	680.26
Adult (age 25 through 44) - Male	479.98	504.23		552.74	663.88	658.12	526.53	545.32
Adult (age 45 or older) - Female	895.94	940.57		896.37	965.93	954.46	931.65	926.16
Adult (age 45 or older) - Male	817.99	865.76		774.16	944.80	982.76	757.59	765.72
Waiver Option								
Dual Eligible								
All Ages - Female	119.15	144.20		146.93	164.63	160.77	159.79	167.17
All Ages - Male	106.70	122.35		129.35	137.19	153.16	144.02	143.65
SSI Children								
Infant (age under 1)	3,197.25	3,007.81		4,170.53	5,714.11	4,316.57	4,585.71	3,873.91
Child (age 1 through 5)	448.74	515.54		603.82	974.26	989.65	619.14	620.30
Child (age 6 through 18)	503.73	605.41		662.84	628.63	477.88	488.03	423.12
Foster Care								
Infant (age under 1)	782.04	465.17		725.06	1,530.56	641.25	1,101.67	1,991.54
Child (age 1 through 5)	223.78	252.45		241.76	341.72	217.99	272.58	280.96
Child (age 6 through 12)	400.89	515.07		503.89	463.11	331.10	403.03	401.36
Child (age 13 or older) - Female	482.17	701.03		781.76	865.06	698.24	575.25	843.69
Child (age 13 or older) - Male	901.29	935.21		709.68	690.41	704.05	563.83	700.31

Appendix B (cont.)

Approved Capitation Payment Rates

KENTUCKY SPIRIT HEALTH PLAN, INC.

YEAR 3 – JULY 1, 2013 THROUGH JUNE 30, 2014

	Year 3							
Families and Children	1	2	3	4	5	6	7	8
Infant (age under 1)	342.55	347.61		369.61	427.41	336.69	438.27	440.00
Child (age 1 through 5)	118.86	104.52		130.57	142.42	107.75	134.68	158.34
Child (age 6 through 12)	133.17	148.09		169.68	159.31	133.58	154.15	170.17
Child (age 13 through 18) - Female	245.84	246.68		259.65	274.35	230.68	231.85	258.81
Child (age 13 through 18) - Male	196.47	237.82		221.17	224.28	178.19	163.38	180.90
Adult (age 19 through 24) - Female	541.18	477.95		497.57	552.89	504.51	501.43	507.60
Adult (age 19 through 24) - Male	173.54	147.20		192.44	203.92	198.63	193.18	171.59
Adult (age 25 through 39) - Female	471.61	415.83		448.54	497.65	473.47	424.65	426.03
Adult (age 25 through 39) - Male	434.14	305.23		349.11	362.46	355.81	275.57	297.09
Adult (age 40 or older) - Female	499.29	414.17		496.57	534.36	491.13	549.02	463.36
Adult (age 40 or older) - Male	569.34	510.30		462.89	595.58	582.19	470.82	411.58
SSI Adults without Medicare								
Adult (age 19 through 24) - Female	582.95	575.68		608.52	537.76	531.93	561.20	518.68
Adult (age 19 through 24) - Male	484.73	359.16		329.18	447.73	499.09	429.72	351.04
Adult (age 25 through 44) - Female	743.61	660.66		714.93	751.10	762.57	781.32	682.20
Adult (age 25 through 44) - Male	480.95	505.76		554.81	667.02	663.07	529.59	546.52
Adult (age 45 or older) - Female	895.81	939.72		891.23	965.54	954.37	930.85	921.53
Adult (age 45 or older) - Male	814.89	867.79		772.19	947.45	987.54	758.63	764.35
Waiver Option								
Dual Eligible								
All Ages - Female	120.58	145.94		148.94	166.80	163.01	162.16	169.81
All Ages - Male	107.89	123.67		130.96	139.00	155.20	145.91	145.93
SSI Children								
Infant (age under 1)	3,200.49	3,017.20		4,198.67	5,755.88	4,338.95	4,617.96	3,908.30
Child (age 1 through 5)	448.26	517.85		606.58	986.08	997.57	627.99	627.91
Child (age 6 through 18)	499.54	600.21		659.89	627.49	474.22	486.41	423.95
Foster Care								
Infant (age under 1)	789.21	467.86		732.32	1,552.41	645.81	1,116.57	2,010.74
Child (age 1 through 5)	225.46	252.61		240.48	347.05	219.05	275.30	284.08
Child (age 6 through 12)	396.20	507.19		495.98	459.52	324.43	400.31	399.13
Child (age 13 or older) - Female	478.19	697.31		777.01	865.02	693.86	575.61	844.50
Child (age 13 or older) - Male	880.71	932.61		707.92	689.50	702.20	564.61	700.90

Appendix C

Management Information System Requirements

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

I. Member Subsystem

A. Inputs

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

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

B. Processing Requirements

The Recipient Data Maintenance function must include the following capabilities:

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

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

8. Maintain identification of Member eligibility in special eligibility programs, such as hospice, etc., with effective date ranges/spans and other data required by the Department.
9. Maintain current and historical date-specific managed care eligibility data for basic program eligibility, special program eligibility, and all other Member data required to support Claims processing, Prior Authorization processing, managed care processing, etc.
10. Maintain and display the same values as the Department for eligibility codes and other related data.
11. Produce, issue and mail a managed care ID card pursuant to the Department's approval within Department determined time requirements.
12. Identify Member changes in the primary care provider (PCP) and the reason(s) for those changes to include effective dates.
13. Monitor PCP capacity and limitations prior to Enrollment of a Member to the PCP.
14. Generate and track PCP referrals 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 XI.

D. On-line Inquiry Screens

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

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

E. Interfaces

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

II. Third Party Liability (TPL) Subsystem

The Third Party Liability (TPL) processing function permits the Contractor to

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

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

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

A. Inputs

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

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

B. Processing Requirements

The TPL processing function must include the following capabilities:

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

- Employer name and tax identification number and address of policyholder;
- Type of policy, type of coverage, and inclusive dates of coverage;
- Date and source of TPL resource verification; and
- Insurance carrier name and tax identification and ID.

1. Provide for multiple, date-specific TPL resources (including Medicare) for each Member.
2. Maintain current and historical information on third-party resources for each Member.
3. Maintain third-party carrier information that includes but is not limited to:
   - Carrier name and ID
   - Corporate correspondence address and phone number
   - Claims submission address(s) and phone number

1. Identify all payment costs avoided due to established TPL, as defined by the Department.
2. Maintain a process to identify previously paid claims for recovery when TPL resources are identified or verified retroactively, and to initiate recovery within sixty (60) Days of the date the TPL resource is known to the Contractor.
3. Maintain an automated tracking and follow-up capability for all TPL questionnaires.
4. Maintain an automated tracking and follow-up capability for post payment recovery actions which applies to health insurance, casualty insurance, and all other types of recoveries, and which can track individual or group claims from the initiation of recovery efforts to closure.
5. Provide for the initiation of recovery action at any point in the claim processing cycle.
6. Maintain a process to adjust paid claims history for a claim when a recovery is received.
7. Provide for unique identification of recovery records.
8. Provide for on-line display, inquiry, and updating of recovery case records with access by claim, Member, carrier, Provider or a combination of these data elements.
9. Accept, edit and update with all TPL and Medicare information received from the Department through the Member eligibility update or other TPL updates specified by the Department.
10. Implement processing procedures that correctly identify and cost avoid claims having potential TPL, and flag claims for future recovery to the appropriate level of detail.
11. Provide verified Member TPL resource information generated from data matches and claims, to the Department for Medicaid Services, in an agreed upon format and media, on a monthly basis.

C. Reports

The following types of reports must be available from the TPL Processing

function by the last day of the month for the previous month:

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

D. On-line Inquiry Screens

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

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

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

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

Provide absent parent canceled court order information generated from data matches with the Division of Child Support Enforcement, to the Department, in an agreed upon format and media, on an annual basis.

III. Provider Subsystem

The provider function accepts and maintains comprehensive, current and historical information about Providers eligible to participate in the Contractor's Network. The maintenance of provider data is required to support Claims and

Encounter processing, utilization/quality processing, financial processing and report functions. The Contractor will be required to electronically transmit provider enrollment information to the Department as requested.

A. Inputs

The inputs to the provider Data Maintenance function include:

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

B. Processing Requirements

The Provider Data Maintenance function must have the capabilities to:

1. Transmit a provider enrollment file to the Department in a specified format;
2. Maintain current and historical provider enrollment applications from receipt to final disposition (approval only);
3. Maintain on-line access to all current and historical provider information, including Provider rates and effective dates, Provider program and status codes, and summary payment data;
4. Maintain on-line access to Provider information with inquiry by Provider name, partial name characters, provider number, NPI, SSN, FEIN, CLIA number, Provider type and specialty, County, Zip Code, and electronic billing status;
5. Edit all update data for presence, format, and consistency with other data in the update transaction;
6. Edits to prevent duplicate Provider enrollment during an update transaction;
7. Accept and maintain the 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, sub-specialty, claim types, and other user-specified Provider status codes and indicators;
12. Accept group provider numbers, and relate individual Providers to

their groups, as well as a group to its individual member Providers, with effective date ranges/spans. A single group provider record must be able to identify an unlimited number of individuals who are associated with the group;

13. Maintain multiple, provider-specific reimbursement rates, including, but not necessarily limited to, per diems, case mix, rates based on licensed levels of care, specific provider agreements, volume purchase contracts, and capitation, with beginning and ending effective dates for a minimum of sixty (60) months.
14. Maintain provider-specific rates by program, type of capitation, Member program category, specific demographic classes, Covered Services, and service area for any prepaid health plan or managed care providers;
15. Provide the capability to identify a Provider as a PCP and maintain an inventory of available enrollment slots;
16. Identify multiple practice locations for a single provider and associate all relevant data items with the location, such as address and CLIA certification;
17. Maintain multiple addresses for a Provider, including but not limited to:
    - Pay to;
    - Mailing, and
    - Service location(s).
18. Create, maintain and define provider enrollment status codes with associated date spans. For example, the enrollment codes must include but not be limited to:
    - Application pending
    - Limited time-span enrollment
    - Enrollment suspended
    - Terminated-voluntary/involuntary
19. Maintain a National Provider Identifier (NPI) and taxonomies;
20. Maintain specific codes for restricting the services for which Providers may bill to those for which they have the proper certifications (for example, CLIA certification codes);
21. Maintain summary-level accounts receivable and payable data in the provider file that is automatically updated after each payment cycle;
22. Provide the capability to calculate and maintain separate 1099 and associated payment data by FEIN number for Providers with changes of ownership, based upon effective dates entered by the Contractor;
23. Generate a file of specified providers, selected based on the Department identified parameters, in an agreed upon Department approved format and media, to be provided to the Department on an agreed upon periodic basis; and
24. Generate a file of provider 1099 information.
25. Reports – Reports for Provider functions are as described in Appendices s K and L.

C. On-line Inquiry Screens

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

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

D. Interfaces

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

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

IV. Reference Subsystem

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

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

A. Inputs

The inputs to the Reference Data Maintenance function are:

1. NDC codes
2. CMS - HCPCS updates
3. ICD-9-CM or 10 and DSM IV 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 IV coding system, which supports relationship editing between diagnosis code and claim information including but not limited to:
   - Valid age
   - Valid sex
   - Family planning indicator
   - Prior authorization requirements
   - EPSDT indicator
   - Trauma diagnosis and accident cause codes
   - Description of the diagnosis
   - Permitted primary and secondary diagnosis code usage
4. Maintain descriptions of diagnoses.
5. Maintain flexibility in the diagnosis file to accommodate expanded diagnosis codes with the implementation of ICD-10 by October 1, 2013.
6. Maintain a drug data set of the eleven (11) digit National Drug Code (NDC), including package size, which can accommodate updates from a drug pricing service and the CMS Drug Rebate file updates; the Drug data set must contain, at a minimum:
   - Unlimited date-specific pricing segments that include all prices and pricing action codes needed to adjudicate drug claims.

- Indicator for multiple dispensing fees
- Indicator for drug rebate including name of manufacturer and labeler codes.
- Description and purpose of the drug code.
- Identification of the therapeutic class.
- Identification of discontinued NDCs and the termination date.
- Identification of CMS Rebate program status.
- Identification of strength, units, and quantity on which price is based.
- Indication of DESI status (designated as less than effective), and IRS status (identical, related or similar to DESI drugs).

7. Maintain a Revenue Center Code data set for use in processing claims for hospital inpatient/outpatient services, home health, hospice, and such.
8. Maintain flexibility to accommodate multiple reimbursement methodologies, including but not limited to fee-for-service, capitation and carve-outs from Capitated or other “all inclusive” rate systems, and DRG reimbursement for inpatient hospital care, etc.
9. Maintain pricing files based on:
    - Fee schedule
    - Per DIEM rates
    - Capitated rates
    - Federal maximum allowable cost (FMAC), estimated acquisition (EAC) for drugs
    - Percentage of charge allowance
    - Contracted amounts for certain services
    - Fee schedule that would pay at variable percentages.
    - (MAC) Maximum allowable cost pricing structure

C. On-line Inquiry Screens

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

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

Provide inquiry screens that display:

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

D. Interfaces

The Reference Data Maintenance function must interface with:

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

service; and
4. NDC Codes.

V. Financial Subsystem

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

A. Inputs

The Financial Processing function must accept the following inputs:

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

B. Processing Requirements

The MIS must perform three types of financial processing: 1) payment processing; 2) adjustment processing; 3) other financial processing. Required system capabilities are classified under one of these headings in this subsection.

C. Payment Processing

Claims that have passed all edit, audit, and pricing processing, or which have been denied, must be processed for payment by the Contractor if the contractor has fee for service arrangements. Payment processing must include the capability to:

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

D. Adjustment Processing

The MIS adjustment processing function must have the capabilities to:

1. Maintain complete audit trails of adjustment processing activities on the claims history files.
2. Update provider payment history and recipient claims history with all appropriate financial information and reflect adjustments in subsequent reporting, including claim-specific and non claim-specific recoveries.
3. Maintain the original claim and the results of all adjustment transactions in claims history; link all claims and subsequent adjustments by control number, providing for identification of previous adjustment and original claim number.

4. Reverse the amount previously paid/recovered and then processes the adjustment so that the adjustment can be easily identified.
5. Re-edit, re-price, and re-audit each adjustment including checking for duplication against other regular and adjustment claims, in history and in process.
6. Maintain adjustment information which indicates who initiated the adjustment, the reason for the adjustment, and the disposition of the claim (additional payment, recovery, history only, etc.) for use in reporting the adjustment.
7. Maintain an adjustment function to re-price claims, within the same adjudication cycle, for retroactive pricing changes, Member liability changes, Member or provider eligibility changes, and other changes necessitating reprocessing of multiple claims.
8. Maintain a retroactive rate adjustment capability which will automatically identify all Claims affected by the adjustment, create adjustment records for them, reprocess them, and maintain a link between the original and adjusted Claim.

E. Other Financial Processing

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

1. Maintain the following information:
   - Program identification (for example, TPL recovery, rate adjustment);
   - Transaction source (for example, system generated, refund, Department generated);
   - Provider number/entity name and identification number;
   - Payment/recoupment detail (for example, dates, amounts, cash or recoupment);
   - Account balance;
   - Reason indicator for the transaction (for example, returned dollars from provider for TPL, unidentified returned dollars, patient financial liability adjustment);
   - Comment section;
   - Type of collection (for example, recoupment, cash receipt);
   - Program to be affected;
   - Adjustment indicator; and
   - Internal control number (ICN) (if applicable).
2. Accept manual or automated updates including payments, changes, deletions, suspensions, and write-offs, of financial transactions and incorporate them as MIS financial transactions for purposes of updating claims history, Provider/Member history, current month financial reporting, accounts receivable, and other

appropriate files and reports.

3. Maintain sufficient controls to track each financial transaction, balance each batch, and maintain appropriate audit trails on the claims history and consolidated accounts receivable system, including a mechanism for adding user narrative.
4. Maintain on-line inquiry to current and historical financial information with access by Provider ID or entity identification, at a minimum to include:
   - Current amount payable/due
   - Total amount of claims adjudication for the period
   - Aging of receivable information, according to user defined aging parameters
   - Receivable account balance and established date
   - Percentages and/or dollar amounts to be deducted from future payments
   - Type and amounts of collections made and dates
   - Both non-claim-specific, and
   - Data to meet the Department's reporting.
5. Maintain a recoupment process that sets up Provider accounts receivable that can be either automatically recouped from claims payments or satisfied by repayments from the provider or both.
6. Maintain a methodology to apply monies received toward the established recoupment to the accounts receivable file, including the remittance advice date, number, and amount, program, and transfer that data to an on-line provider paid claims summary.
7. Identify a type, reason, and disposition on recoupments, payouts, and other financial transactions.
8. Provide a method to link full or partial refunds to the specific Claim affected, according to guidelines established by the Department.
9. Generate provider 1099 information annually, which indicate the total paid claims plus or minus any appropriate adjustments and financial transactions.
10. Maintain a process to adjust providers' 1099 earnings with payout or recoupment or transaction amounts through the accounts receivable transactions.
11. Maintain a process to accommodate the issuance and tracking of non-provider-related payments through the MIS (for example, a refund or an insurance company overpayment) and adjust expenditure reporting appropriately.
12. Track all financial transactions, by program and source, to include TPL recoveries, Fraud, Waste and Abuse recoveries, provider payments, drug rebates, and so forth.
13. Determine the correct federal fiscal year within claim adjustments and other financial transactions are to be reported.
14. Provide a method to direct payments resulting from an escrow or lien request to facilitate any court order or legal directive received.

C. Reports

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

VI. Utilization/Quality Improvement

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

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

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

A. Inputs

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

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

B. Processing Requirements

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

1. Maintain Provider credentialing and recredentialing activities.
2. Maintain Contractor's processes to monitor and identify deviations in patterns of treatment from established standards or norms. Provide feedback information for monitoring progress toward goals, identifying optimal practices, and promoting continuous improvement.
3. Maintain development of cost and utilization data by Provider and services.
4. Provide aggregate performance and outcome measures using standardized quality indicators similar to Medicaid HEDIS as specified by the Department.
5. Support focused quality of care studies.
6. Support the management of referral/utilization control processes and procedures.

7. Monitor PCP referral patterns.
8. Support functions of reviewing access, use and coordination of services (i.e. actions of peer review and alert/flag for review and/or follow-up; laboratory, x-ray and other ancillary service utilization per visit).
9. Store and report Member satisfaction data through use of Member surveys, Grievance/Appeals processes, etc.
10. Provide Fraud, Waste and Abuse detection, monitoring and reporting.

C. Reports

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

VII. Claims Control and Entry

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

VIII. Edit/Audit Processing

The Edit/Audit Processing function ensures that Claims are processed in accordance with Department and Contractor policy and the development of accurate encounters to be transmitted to the department. This processing includes application of non-history-related edits and history-related audits to the Claim. Claims are screened against Member and Provider eligibility information; 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.
2. Edit to assure that the services for which payment is requested are covered.

3. Edit to assure that all required attachments are present.
4. Maintain a function to process all Claims against an edit/audit criteria table and an error disposition file (maintained in the Reference Data Maintenance function) to provide flexibility in edit and audit processing.
5. Edit for prior authorization requirements and to assure that a prior authorization number is present on the Claim and matches to an active Prior Authorization on the MIS.
6. Edit Prior-Authorized claims and cut back billed units or dollars, as appropriate, to remaining authorized units or dollars, including Claims and adjustments processed within the same cycle.
7. Maintain edit disposition to deny Claims for services that require Prior Authorization if no Prior Authorization is identified or active.
8. Update the Prior Authorization record to reflect the services paid on the Claim and the number of services still remaining to be used.
9. Perform relationship and consistency edits on data within a single Claim for all Claims.
10. Perform automated audit processing (e.g., duplicate, conflict, etc.) using history Claims, suspended Claims, and same cycle Claims.
11. Edit for potential duplicate claims by taking into account group and rendering Provider, multiple Provider locations, and across Provider and Claim types.
12. Identify exact duplicate claims.
13. Perform automated audits using duplicate and suspect-duplicate criteria to validate against history and same cycle claims.
14. Perform all components of National Correct Coding Initiative (NCCI) edits
15. Maintain audit trail of all error code occurrences linked to a specific Claim line or service, if appropriate.
16. Edit and suspend each line on a multi-line Claim independently.
17. Edit each Claim record completely during an edit or audit cycle, when appropriate, rather than ceasing the edit process when an edit failure is encountered.
18. Identify and track all edits and audits posted to the claim from suspense through adjudication.
19. Update Claim history files with both paid and denied Claims from the previous audit run.
20. Maintain a record of services needed for audit processing where the audit criteria covers a period longer than thirty-six (36) months (such as once-in-a-lifetime procedures).
21. Edit fields in Appendices D and E for validity (numerical field, appropriate dates, values, etc.).

IX. Claims Pricing

The Claims Pricing function calculates the payment amount for each service according to the rules and limitations applicable to each Claim type, category of service, type of provider, and provider reimbursement code. This process takes

into consideration the Contractor allowed amount, TPL payments, Medicare payments, Member age, prior authorized amounts, and any co-payment requirements. Prices are maintained on the Reference files (e.g., by service, procedure, supply, drug, etc.) or provider-specific rate files and are date-specific.

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

A. Inputs

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

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

B. Processing Requirements

The Claims Pricing function for those Fee For Service contracts the vendor has with providers of the MIS must have the capabilities to:

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

X. Claims Operations Management

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

A. Inputs

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

B. Processing Requirements

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

1. Maintain Claim history at the level of service line detail.
2. Maintain all adjudicated (paid and denied) claims history. Claims

history must include at a minimum:

- All submitted diagnosis codes (including service line detail, if applicable);
- Line item procedure codes, including modifiers;
- Member ID and medical coverage group identifier;
- Billing, performing, referring, and attending provider Ids and corresponding provider types;
- All error codes associated with service line detail, if applicable;
- Billed, allowed, and paid amounts;
- TPL and Member liability amounts, if any;
- Prior Authorization number;
- Procedure, drug, or other service codes;
- Place of service;
- Date of service, date of entry, date of adjudication, date of payment, date of adjustment, if applicable.

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

C. Reports

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

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

Additional detail found in Appendix L.

Appendix D

Encounter Data Submission Requirements

I. Contractor's Encounter Record

At a minimum, the Contractor will be required to electronically provide encounter Record to the Department on a weekly basis. Encounter Records must follow the format, data elements and method of transmission specified by the Department.

Encounter data will be utilized by the Department for the following purposes: 1) to evaluate access to health care, availability of services, quality of care and cost effectiveness of services, 2) to evaluate contractual performance, 3) to validate required reporting of utilization of services, 4) to develop and evaluate proposed or existing capitation rates, and 5) to meet CMS Medicaid reporting requirements.

A. Submissions

The Contractor is required to electronically submit Encounter Record 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 for the previous month. Monthly Encounter Record 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 returned to the Contractor in their entirety for correction and resubmission by the Contractor. Encounter data transmissions with a threshold error rate not exceeding 5% will be accepted and processed by the Department. Only those encounters that hit threshold edits 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 Record 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 by January 1, 2012. 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, 2013.

   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 Contractor must also use appropriate provider numbers as directed by the Department for Encounter data. The Encounter Record 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. The Contractor shall have the opportunity to dispute appropriateness of assessment of penalties prior to them occurring to attest to ongoing efforts regarding data acceptance.

C. Annual Validity Study

The Department will conduct an annual validity study to determine the completeness, accuracy and timeliness of the Encounter Record provided by the Contractor.

Completeness will be determined by assessing whether the Encounter record transmitted includes each service that was provided. Accuracy will be determined by evaluating whether or not the values in each field of the Encounter record accurately represent the service that was provided. Timeliness will be determined by assuring that the Encounter record 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 Record was provided to the 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.

II. Encounter Data Requirements

A. HIPAA 4010 Companion Guides

DMS Encounter Data Requirements are defined by HIPAA 4010 Companion Guides and are available at: https://ddipwb.kymmis.com -/KYXIXDDI/Subsystem/EDI and Claim Capture/Companion Guides/KY New MMIS Companion Guides

B. HIPAA 5010 Companion Guides
Effective January 1, 2012 the Department will be implementing HIPAA 5010 Companion Guides and will be provide upon completion.

III. Department's Utilization of Submitted Encounter Records

The Contractor's Encounter Records 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.

Appendix E

Encounter Data Submission Quality Standards

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

A. Edit each data element on the Encounter Record for required presence, format, consistency, reasonableness and/or allowable values;
B. Edit for Member eligibility;
C. Perform automated audit processing (e.g. duplicate, conflict, etc.) using history Encounter Record and same-cycle Encounter Record;
D. Identify exact duplicate Encounter Record;
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 Record.

II. Data Quality Standards for Evaluation of Submitted Encounter Data Fields

DATA QUALITY STANDARDS FOR EVALUATION OF SUBMITTED ENCOUNTER DATA FIELDS Based on CMS Encounter Validation Protocol		
Data Element	**Expectation**	**Validity Criteria**
Enrollee ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts SSN.	100% valid
Enrollee Name	Should be captured in such a way that makes separating pieces of name easy. There may be some confidentiality issues that make this difficult to obtain. If collectable, expect data to be present and of good quality	85% present. Lengths should vary and there should be at least some last names >8 digits and some first names < 8 digits. This will validate that fields have not been truncated. Also verify that a high percentage have at least a middle

DATA QUALITY STANDARDS FOR EVALUATION OF SUBMITTED ENCOUNTER DATA FIELDS Based on CMS Encounter Validation Protocol		
Data Element	**Expectation**	**Validity Criteria**
		initial.
Enrollee Date of Birth	Should not be missing and should be a valid date.	2% missing or invalid
MCO/PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in provider enrollment file.	95% valid
Attending Provider NPI	Should be an enrolled provider listed in provider enrollment file (also accept the MD license number if listed in provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, with zip code being strongly advised.	• 95% with valid county code • > 95% with valid zip code (if available)

Appendix F

Third Party Liability/Coordination of Benefits Requirements

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

A. Maintaining an MIS that includes:

1. Third Party Liability Resource File
   - Policy Begin Date
   - Policy End Date
   - Policyholder Name
   - Policyholder Address
   - Insurance Company Name
   - Insurance Company Address
   - Type of Coverage
   - Policy Type
   - HIC Number

   a) Cost Avoidance - Use automated daily and monthly TPL files to update the Contractor's MIS TPL files as appropriate. This information is to cost avoid claims for members who have other insurance.

   b) DMS shall require the Contractor to do data matches with insurers. DMS shall require the Contractor to obtain subscriber data and perform data matches with a specified list of insurance companies, as defined by DMS.

   c) Department for Community Based Services (DCBS) - Apply Third Party Liability (TPL) information provided electronically on a daily basis by DMS through its contract with DCBS to have eligibility caseworkers collect third party liability information during the Recipient application process and reinvestigation process.

   d) Workers' Compensation -. The data is provided electronically on a quarterly basis by DMS to the Contractor. This data should be applied to TPL files referenced in I.A.1.a (Commercial Data Matching) in this Appendix.

2. Third Party Liability Billing File
   - MAID
   - TCN
   - Policy#
   - Carrier Billed
   - Amount Paid
   - Amount Billed
   - Amount Received

- TCN Status Code (Code identifies if claim was denied and the reason for the denial)
- Billing Type (Code identifies claim was billed to insurance policy)
- Date Billed
- Date Paid or Denied
- Date Rebilled

a) Commercial Insurance/Medicare Part B Billing - The Contractor's MIS should automatically search paid claim history and recover from providers, insurance companies or Medicare Part B in a nationally accepted billing format for all claim types whenever other commercial insurance or Medicare Part B coverage is discovered and added to the Contractor's MIS that was unknown to the Contractor at the time of payment of a claim or when a claim could not be cost avoided due to federal regulations (pay and chase) which should have been paid by the health plan. Within sixty (60) Days from the date of identification of the other third party resource billings must be generated and sent to liable parties.

b) Medicare Part A - The Contractor's MIS should automatically search paid claim history and generate reports by Provider of the billings applicable to Medicare Part A coverage whenever Medicare Part A coverage is discovered and added to the Contractor's MIS that was unknown to the Contractor at the time of payment of a claim. Providers who do not dispute the Medicare coverage should be instructed to bill Medicare immediately. The Contractor's MIS should recoup the previous payment from the Provider within sixty (60) days from the date the reports are sent to the Providers, if they do not dispute that Medicare coverage exists.

c) Manual Research/System Billing - System should include capability for the manual setup for billings applicable to workers' compensation, casualty, absent parents and other liability coverage that require manual research to determine payable claims.

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

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

B. Coordination of Third Party Information (COB)

1. Division of Child Support Enforcement (DCSE)

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

2. Casualty Recoveries

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

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

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

C. Claims

1. Processing

a) Contractor MIS edits:

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

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

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

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

II. DMS shall be responsible for the following:

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

Appendix G

Network Provider File Layout Requirements

I. MCO Provider Network

Submit one delimited text file per network. Submit one record for each provider type to include the values in the layout. Template to be supplemented with additional requirements.

Field Name	Field Size	Valid Values
Provider Type	2	Utilize valid values from sheet titled Medicaid Provider Types
Provider Contracted	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.
Provider License	10	Must be submitted for physicians and leave blank if physician is licensed in a state other than Kentucky.
National Provider Identifier (NPI)	10	Must be submitted for providers required to have an NPI.
Medicaid Provider ID	10	Provider ID assigned by Kentucky Medicaid. Must be submitted - if known.
Primary Specialty Code	3	Utilize valid values from sheet titled Medicaid Provider Specialties (Required Field even for PCPs)
Secondary Specialty Code	3	Utilize valid values from sheet titled Medicaid Provider Specialties
Name	50	If a physician name, enter as last name, first name, MI.
Address Line 1	50	DO NOT SUBMIT PO BOX OR MAILING ADDRESS. THIS MUST BE LOCATION ADDRESS!
Address Line 2	50	DO NOT SUBMIT PO BOX OR MAILING ADDRESS. THIS MUST BE LOCATION ADDRESS!

City	50	
State	2	
Zip Code	5	
County Code	3	County Code of the Provider's location address. See sheet titled for Kentucky County Codes
Phone Number	15	Do not include dashes, etc.
Latitude	11	Latitude of the Provider's location address. Precision to the 6th digit. Must be in format 99.999999
Longitude	11	Longitude of the Provider's location address. Precision to the 6th digit. Must be in format -99.999999
PCP Specialist or Both	1	Valid entries are P, S or B. P=PCP, S=Specialty, B=Both. Leave blank for all other providers.
PCP Open or Closed Panel	1	Mandatory for PCP. Valid entries are O or C. O=Open, C=Closed. Leave blank for all other providers.
PCP Panel Size	9	PCP Provider's maximum panel size
PCP Panel Enrollment	9	PCP Provider's current panel enrollment count

Appendix H

Credentialing Process 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

Appendix I

Covered Services

I. Contractor Covered Services

A. Alternative Birthing Center Services
B. Ambulatory Surgical Center Services
C. Chiropractic Services
D. Community Mental Health Center Services
E. Dental Services, including Oral Surgery, Orthodontics and Prosthodontics
F. Durable Medical Equipment, including Prosthetic and Orthotic Devices, and Disposable Medical Supplies
G. Early and Periodic Screening, Diagnosis & Treatment (EPSDT) screening and special services
H. End Stage Renal Dialysis Services
I. Family Planning Clinic Services in accordance with federal and state law and judicial opinion
J. Hearing Services, including Hearing Aids for Members Under age 21
K. Home Health Services
L. Hospice Services (non-institutional only)
M. Impact Plus Services
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 as defined in 907 KAR 1:705
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. Therapeutic Evaluation and Treatment, including Physical Therapy, Speech Therapy, Occupational Therapy
DD. Transportation to Covered Services, including Emergency and Ambulance

Stretcher Services

EE. Urgent and Emergency Care Services

FF. Vision Care, including Vision Examinations, Services of Opticians, Optometrists and Ophthalmologists, including eyeglasses for Members Under age 21

GG. Specialized Children's Services Clinics

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, 10 and 11) 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 administrative regulations are also accessible via the Internet at http//www.ky.gov

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.

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;
- 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; and
- Services for substance abuse diagnoses in adults except for pregnant women, or in cases where acute care physical health services related to substance abuse or detoxification are necessarily required.

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 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 (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 the following statutes or administrative regulations:

- Medical Necessity and Clinical Appropriate Determination Basis (907 KAR 3:130)
- Alternative Birthing Center Services (907 KAR 1:180)
- Ambulatory Surgical Center and Anesthesia Services (907 KAR 1:008)
- Chiropractic Services (907 KAR 3:125)
- Commission for Children with Special Health Care Needs (907 KAR 1:440)

Certain Medically Necessary services provided by the Commission for Children with Special Health Care Needs for Members identified with special needs.

Coverage includes physician, EPSDT, dental, occupational therapy, 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 Services (907 KAR 1:044 and 907 KAR 3:110)
- 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)
- 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 & 10:376)
- Hospital Outpatient Services (907 KAR 10:014 & 10:376)
- Laboratory Services (907 KAR 1:028)
- Medicare Non-Covered Services (907 KAR 1:006)
- Mental Health Inpatient Services (907 KAR 10:016)
- Mental Health Outpatient Services (see physician, community mental health
  center, FQHC and RHC)
- Nursing Facility Services (907 KAR 1:022 & 1:374)
- Other Laboratory and X-ray Provider Services (907 KAR 1:028)
- Outpatient Pharmacy Prescriptions and Over-the-Counter Drugs including
- Mental/Behavioral Health Drugs (907 KAR 1:019, KRS 205.5631, 205,5632,
- KS 205.560) Psychiatric Residential Treatment Facility Services – (907 KAR 1:505)
- Physicians and Nurses in Advanced Practice Medical Services (907 KAR 3:005 and 907 KAR 1:102)
- Podiatry Services (907 KAR 1:270)
- Preventive Health Services (907 KAR 1:360)
- Primary Care and Rural Health Center Services (907 KAR 1:054, 1:082, 1:418 and 1:427)
- Sterilization, Hysterectomy and Induced Termination of Pregnancy Procedures (Sterilizations of both male and female Members are covered only when performed in compliance with federal regulations 42 CFR 441.250.)

These services are covered in accordance with Kentucky Law (KRS 205.560) and a United States District Court judge ruling in the case of *Glenda Hope, et al.*

- Targeted Case Management Services (907 KAR 1:515, 907 KAR 1:525, 907 KAR 1:550 and 907 KAR 1:555)
- Transportation, including Emergency and Non-emergency Ambulance (907 KAR 1:060)
- Vaccines for Children (VFC) Program (907 KAR 1:680) Vision Services (907 KAR 1:038)
- Specialized Children's Services Clinics (907 KAR 3:160)

Appendix J

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

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

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

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

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

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

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

Health History:	
Complete History	Initial Visit
Interval History	Each Visit
By History /Physical Exam:	
Developmental Assessment	Each Visit
(Age appropriate physical and mental health milestones)	
Nutritional Assessment	Each Visit
Lead Exposure Assessment	6 mo. through 6 yr. age visits
Physical Exam:	
Complete/ Unclothed	Each Visit
Growth Chart	Each Visit
Vision Screen	Assessed each visit *According to recommended medical standards (AAP1)
Hearing Screen	Assessed Each Visit *According to recommended medical standards (AAP1)
Laboratory:	
Hemoglobin/ Hematocrit	*According to recommended medical standards (AAP1)
Urinalysis	*According to recommended medical standards (AAP1)
Lead Blood Level (Low Risk History)	12 mo. and 2 year age visit
Lead Blood Level (High Risk History)	Immediately
Cholesterol Screening	*According to recommended medical standards (AAP1)
Sickle Cell Screening	Documentation X 1
Hereditary/ Metabolic Screening (Newborn Screening)	* According to Kentucky statute
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 OPVmedical standards (AAP1, ACIP2, Hepatitis BAAFP3)

HiB

Immunizations: Cont.
MMR
Varicella
Td
PPD

Health Education/ Anticipatory Guidance
(Age Appropriate) Each Visit

Dental Referral Age 1

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

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

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

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

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

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

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

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

Appendix K

Reporting Requirements

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

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

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

I. EXECUTIVE SUMMARY

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

II. ELIGIBILITY/ENROLLMENT

A. Enrollment Changes During the Quarter

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

B. PCP Changes During the Report Period

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

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

PCP Changes During the Report Period

Physician/ Group ID	Physician/Group Name	Beginning Panel Enrollment Size	Number of Members that requested voluntary change	Overall Net Change (+-) in Panel Enrollment Size	Ending Panel Enrollment Size	Percent Change	PCP Assignment initiated by who: Member, Provider or Contractor

C. PCP's with Panel Changes Greater than 50 or 10%
Briefly narrate reasons for those voluntary member transfers that exceed the lessor of 50 or 10% of total panel. The purpose for the change is to place emphasis on looking at reasons for voluntary changes and less on routine member transfers due to new enrollment activity. (See note under B. above for annual report

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

Provide an electronic copy of PCPs w/n panel changes greater than 50% or 10% format below	Physician/Group ID	Physician /Group Name	Beginning Panel Enrollment Size	Number of Members that requested voluntary change	Percent Change	Ending Panel Enrollment Size

III. ACCESS/DELIVERY NETWORK

A. GeoNetworks Reports and Maps
Distribution and Analysis of Current Provider Network and Beneficiaries
Annually, due on July 31 of each year include the following GeoNetworks reports: Title page, table of contents, accessibility standard comparison, accessibility standard detail, accessibility detail, accessibility summary, member map, provider listing, provider map, service area detail. Discuss monitoring and analysis of the GeoNetwork reports and maps to determine utilization patterns especially those of Members with special healthcare needs. Do not include member listing. Include a 3 computer diskette containing the GeoNetworks .dbf files used for the members and providers as well as the GeoNetworks .rpt file(s).

B. Access Issues/Problems Identified During the Report Period and/or Remedial Action Taken
Provide specific information on the nature of any access problems identified and any plans or remedial action taken. Include a summary of all provider and member complaints about access issues, responses to member and provider survey questions dealing with access, analysis of GeoAccess reports, and notification of the Contractor by DMS of network access problems.

C. Listing of Providers Denied Participation
Provide a listing of providers that requested participation in the MCO network during the report period but were denied. Include reasons for denials.

Provide a summary (count) of providers that terminated their contract(s) with the Contractor during the report period and the reasons for the

terminations. (Sample listing of termination reasons below. Add other reasons as needed.)

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

D. Subcontracting Issues/Monitoring Efforts

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

IV. QUALITY ASSURANCE AND IMPROVEMENT

A. Internal Quality Assurance Activities During the Report Period

1. Summary of QI Activities

Describe the quality assurance activities during the report period directed at improving the availability, continuity, and quality of services. Examples include problems identified from utilization review to be investigated, medical management committee recommendations based on findings, special research into suspected problems and research into practice guidelines or disease management.

2. Monitoring of Indicators, Benchmarks and Outcomes

Include a narrative on the Contractor's progress in developing or obtaining baseline data and the required health outcomes, including proposed sampling methods and methods to validate data, to be used as a progress comparison for the Contractor's quality

improvement plan. The report should include how the baseline data for comparison will be obtained or developed and what indicators of quality will be used to determine if the desired outcomes are achieved.

3. Performance Improvement Projects
   Report on the progress and status of performance improvement projects.

4. Utilization of Sub-Populations and Individuals with Special Healthcare Needs
   Discuss any issues that arose during the report period that related to persons associated with sub-populations and individuals with special healthcare needs. Examples of 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.

5. Satisfaction Survey(s)
   Describe results of any satisfaction survey that was conducted by the Contractor during the report period, if applicable. *(Note: surveys are conducted each year, so this section will be completed during one quarter for the providers and one for the members.)*

6. Evidence-based guidelines for practitioners
   Report on assessment activities during the report period resulting in development and distribution of practice guidelines for providers. Provide an analysis of the effectiveness in improving patterns of care.

B. Activities Related to EPSDT, Pregnant Women, Maternal and Infant Health

1. Overview of Activities
   Provide a summary of the activities of these programs, and trends noted in prenatal visit appropriateness, birth outcomes including death, and program interventions, during the last reporting period. If any of the programs have changed during the reporting period, please describe the change in the programs.

2. EPSDT Screening Rates
   Describe activities of the EPSDT staff, including outreach, education, and case management. Provide data on levels of compliance during the report period (including screening rates) with EPSDT regulations.

   The CMS-416 report is an additional report required annually. The Department specifications for the CMS 416 (EPSDT) shall be in

compliance with the CMS-416: Annual EPSDT Participation Report and shall be based on Federal Fiscal Year (FFY).

C. Credentialing and Re-credentialing Activities During the Report Period
Summarize the Contractor's credentialing and re-credentialing activities.

D. Fraud, Waste and Abuse Activities During the Report Period
Discuss Contractor efforts to monitor Fraud, Waste and Abuse.

V. GRIEVANCES/APPEALS

A. Grievance Activities During the Report Period
Summarize the grievances received by the Contractor during the reporting period. Provide the number, type and resolution of grievances during the report period. (Note: these logs are the "number, type and resolution." Also under the BBA – complaint and grievances are the same.)

B. Appeal Activities during the Report Period
Summarize the appeals received by the Contractor during the reporting period. Provide the number, type and resolution of appeals during the report period.

C. Trends or Problem Areas
Discuss any trends or problem areas identified in the appeals and grievances, and the Contractor's efforts to address any trends.

VI. BUDGET NEUTRALITY/FISCAL ISSUES

A. Budgetary Issues for the Report Period
Provide a narrative of budgetary issues including changes in appropriations, adjustments in the upper payment limits, etc.

B. Potential/Anticipated Fiscal Problems
Provide a narrative of anticipated fiscal problems or issues at the Contractor level. Include such topics as payment of claims, financial solvency, etc.

VII. UTILIZATION

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

b) Top Therapeutic Classes based on top 50 Drugs – Cost and Number of Prescriptions
c) Pharmacy Utilization Statistics

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

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

75 - 84							
85+							
Total							

Third Month of the Report Period

Unduplicated Number of Members During the Month By Age And Category of Medicaid Eligibility

AGE	AFDC	SOBRA	FOSTER	KCHIP	SSI W/ MEDICARE	SSI WO/ MEDICARE	TOTAL
< 1							
1 < 2							
2 < 3							
3 < 6							
6 < 10							
1 - 9							
10 - 19							
20 - 44							
45 -64							
65 - 74							
75 - 84							
85+							
Total							

Total Member Months During the Report Period By Age And Category of Medicaid Eligibility (Note: Sum the months above for each cell)

AGE	AFDC	SOBRA	FOSTER	KCHIP	SSI W/ MEDICARE	SSI WO/ MEDICARE	TOTAL
< 1							
1 < 2							
2 < 3							
3 < 6							
6 < 10							
1 - 9							
10 - 19							
20 - 44							
45 -64							
65 - 74							
75 - 84							
85+							
Total							

Version: DMS Approved 06/2011

Notes: All reports are based on date of service

Unduplicated members include all members eligible at any time during the month regardless of date.

Retroactive eligibility **shall** be included in the "total" table. Footnote accordingly.

For report periods greater than 3 months, simply include a table for each month.

Utilization Report 2								
Region XX								
Reporting Period Covers: _/_/_ - _/_/_								
Ambulatory Care by Age Breakdown								
	Outpatient Visits (Excludes MH/CD)		**All Emergency Room Visits (Include outpatient ER and ER resulting in inpatient admissions)**		**Ambulatory Surgery / Procedures**		**Observation Room Stays Resulting in Discharge**	
Age	Visits	Visits / 1,000 Member Months	Visits	Visits / 1,000 Member Months	Procedures	Procedures / 1,000 Member Months	Stays	Stays / 1,000 Member Months
<1								
1-9								
10-19								
20-44								
45-64								
65-74								
75-84								
85+								
Total								
Version: DMS Approved 06/2011								
Notes: All reports are based on date of service								
ER Utilization shall be according to HEDIS specifications to include HCFA-1500 Claims with Place of Service code 23.								

UTILIZATION REPORT 3				
Region XX				
Reporting Period Covers: _/_/_ - _/_/_				
Emergency Care and Ambulatory Surgery Resulting in Hospital Admission				
	Emergency Room Visits Resulting in Inpatient Admission Same Day		**Ambulatory Surgery / Procedures* Resulting in Inpatient Admission within 30 days**	
Age	Visits	Visits / 1,000 Member Months	Procedures	Procedures / 1,000 Member Months
<1				
1-9				
10-19				
20-44				
45-64				
65-74				
75-84				
85+				
Total				
Version: DMS Approved 06/2011				
*** Use the Medicare base rate file for ambulatory surgery procedures**				

UTILIZATION REPORT 4						
Region XX						
Reporting Period Covers: _/_/_ - _/_/_						
Emergency Care by ICD-9 code						
ICD-9 Diagnosis 3 digit prefix	Diagnosis Description	**In-Plan ER Visits**	**Out-of-Plan ER Visits**	**In-Plan Urgent Care Visits**	**Total ER and Urgent Care Visits**	**ER-UC Visits / 1,000 Member Months**
Report includes the top 50 Primary ICD-9 CM Diagnosis Codes appearing on the UB-92 using the first three (3) digit prefix.						
"In-Plan" is defined as an ER provider under contract or letter of agreement with the Contractor.						
Per 1000 calculations are monthly average						
Version: DMS Approved 06/2011						

UTILIZATION REPORT 5									
Region XX									
Reporting Period Covers: _/_/_ - _/_/_									
Home Health Utilization									
Age	Unduplicated Patients Served	Visits for Infusion Therapy	Visits for Oxygen and/or Respiratory Therapy	Visits for Physical Therapy	Visits for Occupational Therapy	Visits for Speech Therapy	Other Visits	Total Visits	Total Visits / 1,000 Member Months
<1									
1-9									
10-19									
20-44									
45-64									
65-74									
75-84									
85+									
Total									
Use revenue codes and HCPC codes appropriate for RN, LPN, RT, OT, PT, ST, CNA, Oxygen and Respiratory Therapy, Infusion Therapy.									
Do not include DME in this report.									
Version: DMS Approved 06/2011									
Note: All reports based on date of service.									

Utilization 6				
Region XX				
Reporting Period Covers: _/_/_ - _/_/_				
Ambulatory Care by Provider Type and Category of Aid				
Category	Visits w/ Participating Providers	Visits w/ Non-participating Providers	Total Visits	Visits / 1,000 Member Months
1. Primary Care Providers				
AFDC				
SOBRA				
Foster Care				
KCHIP				
SSI w/o Medicare				
SSI w/ Medicare				
2. FQHC & RHC				
AFDC				
SOBRA				
Foster Care				
KCHIP				
SSI w/o Medicare				
SSI w/ Medicare				
3. Eye Care Providers				
AFDC				
SOBRA				
Foster Care				
KCHIP				
SSI w/o Medicare				
SSI w/ Medicare				
4. Dentists				
AFDC				
SOBRA				
Foster Care				
KCHIP				
SSI w/o Medicare				
SSI w/ Medicare				
5. Physicia				

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

UTILIZATION REPORT 7A - Top 50 Drugs

Region XX

Reporting Period Covers: _/_/_ - _/_/_

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

UTILIZATION REPORT 7B - Top Therapeutic Classes (Based on Top 50 Drugs)					
Region XX					
Reporting Period Covers: _/_/_ - _/_/_					
	Top Therapeutic Class	Cost	Total Number of RX		
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
(Add more rows as needed per the top 50 drugs.)					

UTILIZATION REPORT 7C - Pharmacy Utilization by Month				
Region XX				
Reporting Period Covers: _/_/_ - _/_/_				
Month	**# Members utilizing RX benefit**	**Total RX per month**	**Cost PMPM (All drug Costs)**	
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
Yearly Total:				

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

C. Monitoring Activities Related to Utilization and Access to Care
Discuss the Contractor's use of encounter data and utilization reports to monitor utilization of services and access to care.

D. Utilization Trends/Patterns Identified During the Report Period
Analyze and discuss trends in utilization and any unusual patterns about which the Contractor will take subsequent action. Also, discuss areas where over- or under-utilization has been influenced appropriately, i.e., pharmacy and ER utilization management.

E. Summary of Denials Rendered during the Report Period
Analyze and discuss any unusual patters in the denials rendered during the reporting period.

VIII. Quarterly Benefit Payment Report

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

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

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

COS #	Category of Service	October-	November-	December-	Quarterly Total
	Medicaid Mandatory Services				
02	Inpatient Hospital				
12	Outpatient Hospital				
32	EPSDT Related				
34	Clinical Social Worker				
37	Physical Therapist Crossover				
38	Occupational Therapist				
39	Psychologist Crossover				
40	DME				
41	Primary Care				
43	Rural Health Clinic				
44	Nurse Midwife				
45	Family Planning				
46	Home Health				
47	Independent Laboratory				
48	EPSDT Preventive				
62	Emergency Transportation				
63	Non-Emergency Transportation				
67	Vision				
72	Dental				
74	Physician				
75	Certified Nurse Practitioner				
81	Hearing				
90	Comprehensive Outpatient Rehab Facility (CORF)				
92	Psychiatric Distinct Part Unit				
93	Rehab Distinct Part Unit				
94	Physician Assistant				
	Subtotal	**$**	**$**	**$**	**$**
	Medicaid Optional Services				
03	Mental Hospital				
04	Renal Dialysis Clinic				
08	Psychiatric Residential				

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

	KCHIP	**$**	**$**	**$**	**$**

	TOTAL	**$**	**$**	**$**	**$**

	Reinsurance	**$**	**$**	**$**	**$**

	Pharmacy Rebates	**$**	**$**	**$**	**$**

	GRAND TOTAL	**$**	**$**	**$**	**$**

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

COS #	Category of Service	October-	November-	December-	Quarterly Total
	Medicaid Mandatory Services				
02	Inpatient Hospital				
12	Outpatient Hospital				
32	EPSDT Related				
34	Clinical Social Worker				
37	Physical Therapist Crossover				
38	Occupational Therapist				
39	Psychologist Crossover				
40	DME				
41	Primary Care				
43	Rural Health Clinic				
44	Nurse Midwife				
45	Family Planning				
46	Home Health				
47	Independent Laboratory				
48	EPSDT Preventive				
62	Emergency Transportation				
63	Non-Emergency Transportation				
67	Vision				
72	Dental				
74	Physician				
75	Certified Nurse Practitioner				
81	Hearing				
90	Comprehensive Outpatient Rehab Facility (CORF)				
92	Psychiatric Distinct Part Unit				
93	Rehab Distinct Part Unit				
94	Physician Assistant				
	Subtotal	**$**	**$**	**$**	**$**
	Medicaid Optional Services				
03	Mental Hospital				
04	Renal Dialysis Clinic				
08	Psychiatric Residential				

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

	TOTAL	**$**	**$**	**$**	**$**

	Reinsurance	**$**	**$**	**$**	**$**

	Pharmacy Rebates	**$**	**$**	**$**	**$**

	GRAND TOTAL	**$**	**$**	**$**	**$**

IX. Abortion Procedure Report

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

- MCO Region
- Member ID
- Member DOB
- Provider ID

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

X. Systems

A. Systems and Data Development Issues

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

B. Claims Processing Timeliness/Encounter Data Reporting
Provide a discussion of the status on the timeliness of encounter data reporting and the processing of claims, including steps taken by the Contractor to correct problems.

XI. OTHER CONTRACTOR ACTIVITIES

A. Organization Changes
Identify organizational changes relating to the Contractor.

B. Administrative Changes
Identify administrative changes relating to the Contractor.

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

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

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

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

A. BHDID General Reporting Requirements

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

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

B. BHDID Additional Reporting Requirements

1. Network Capacity

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

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

b) Utilization by Chronic Cases
- Number of crisis calls/1000
- Number of counseling sessions/1000

c) Number of days wait for initial appointment
- Total
- Emergency
- Urgent
- Routine

d) Utilization by Medicaid Enrollees
- Number of crisis calls/1000

- Number of counseling sessions/1000
- Number of days wait for initial appointment (Should include: Total; Emergency; Urgent; and Routine)
- Number of Minutes to Reach a Clinician by Telephone in an Emergency
- Number of Days to Reach a Clinician by Telephone (non-emergency)
- Prevention Visits per 1000 Medicaid Enrollees

e) Outcomes for Chronic Cases (SMI, SED)
- Number of psychiatric hospitalizations/1000
- Percent hospitalized
- Pharmaceutical expenditures/1000
- Number ER visits/1000
- Percent adhering to recommended course of mental health treatment
- Percent of clients satisfied with access and quality of mental health services
- Health status

f) Outcomes for Medicaid Enrollees
- Number of psychiatric hospitalizations/1000
- Percent hospitalized for psychiatric problems
- Pharmaceutical expenditures/1000
- Number ER visits/1000
- Percent adhering to recommended course of behavioral health treatment
- Percent of clients satisfied with access and quality of behavioral health services
- Percent maintaining employment or staying in school while in mental health treatment
- Percent with permanent housing after mental health treatment
- Percent arrested or incarcerated after mental health treatment
- Health status

2. Financial / Payment

a) MCO shall be required to make payments to providers upon receipt of filed claims (not to exceed thirty days or with respective penalty after sixty days, ninety days, etc.)

b) MCO shall report monthly on per member, per

month expenses for behavioral health services for children / youth and for adults

c) MCO shall report monthly on per member, per month expenses for behavioral health services for adults with SMI and children/youth with SED

XIII. Other Quarterly Report

Personal Information Form Template

	Total # of New Member Packets Mailed by Month	Total # of PIFs Received by Month
October	0	0
November	0	0
December	0	0
Total for Quarter	**0**	**0**

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

Call Result	1st Attempt: Call Results	2nd Attempt: Call Results	Grand Total: Call Results
No Answer	0	0	0
Phone number incorrect	0	0	0
Left message	0	0	0
Phone number not listed	0	0	0
Member disenrolled from Contractor	0	0	0
Not convenient time	0	0	0

Member not home	0	0	0
Did Not Want Assistance	0	0	0
Phone Busy	0	0	0
Assisted Member to Fill Out PIF	0	0	0
Doesn't speak English	0	0	0
Filled Out PIF and Mailed	0	0	0
Total # of call results:	**0**	**0**	**0**

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

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

Provider Termination Report
Monthly Report - Month/Year
Ran as of Date - MM/DD/YY

NPI	Last	First	Title	Group	Add 1	Add 2	City	St	Zip	County	Reason

Provider Denial Report
Monthly Report - Month/Year
Ran as of Date - MM/DD/YY

NPI	Last	First	Title	Group	Add 1	Add 2	City	St	Zip	County	Reason

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

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

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

Case Number	Investigator	Subject Type	Date Opened	Date Closed	Original Report Summary	Findings	Potential Recovery

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

Monthly Provider Enrollment Report								
NPI	Provider Name	Tax ID	Owner	Address	City	State	Zip	County

Expenditures Related to Contractor's Operations

Category	Positions	Salary[1]	Bonus[2]	Other Compensation[3]	Travel	Other Expenses	Reporting Period Begin Date	Reporting Period 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							
	Sub-Total							
Executive Management	All other Executive Management Staff							

[1] Where an individual serves Contractor lines of business other than Kentucky Medicaid Managed Care, the Contractor may disclose an estimated allocation based on the time allocated to its Kentucky Medicaid Managed Care line of business. Information related to the Contractor's ultimate parent company's executive management need not be disclosed.

[2] Unless guaranteed, or actually paid during the period, bonuses disclosed may be target amounts for the period disclosed expressed as a percentage of base salary.

[3] "Other Compensation" is limited to other cash compensation actually paid during the period, and may exclude amounts realized or realizable during the period through the grant, vesting, or exercise of stock options, restricted stock, stock appreciation rights, phantom stock plans, or other long term non-cash incentives.

Executive Management	All Other Non-Executive Management Staff							
All Categories	Total							

Appendix L

Reporting Deliverables

Report Name	Report Description	Report Frequency						Submitted to
		WKL	MTH	QTR	ANN	As Revised / Other	Due Date	
Financial								
Annual Financial Statements	Contractor must provide a copy to the DMS of the most recent annual financial statements, as submitted to and required by DOI for each covered contract year				X	120 days following each fiscal year		DOI
Annual Audited Financial Statements	Contractor must provide a copy to the DMS of the most recent annual audited financial statements, as submitted to and required by DOI for each covered contract year				X	Concurrent with filing same with the domiciliary Insurance regulator		DOI and DMS
Quarterly Financial Reports	Provide financial reports in format and content as prescribed by NAIC and cover letter			X		Concurrent with filing same with the domiciliary		DMS

						Insurance regulator d		
Executive Summary								
Executive Summary	Include a summary of any significant activities, problems or issues and any program modifications			X		30 days after quarter end		DMS
Eligibility/Enrollment								
Enrollment Changes During the Quarter	Summarize all changes in the number of persons enrolled during the report period			X		30 days after quarter end		DMS
PCP Changes During the Report Period	Identify PCPs with voluntary member enrollment change activity and percent change in members per PCP			X	X	30 days after quarter end	April 30th	DMS
PCP Assignments Initiated by the Contractor	Provide number of PCP assignments initiated by the Contractor			X		30 days after quarter end		DMS
PCP Changes by Member	Provider number of all member PCP changes			X		30 days after quarter end		DMS

PCP's with Panel Changes Greater than 50 or 10% - Table	Provide an electronic file of all PCPs with panel changes greater than 50 or 10%			X		30 days after quarter end		DMS
PCP's with Panel Changes Greater than 50 or 10% - Narrative Summarization	Briefly narrate reasons for those voluntary member transfers that exceed the lesser of 50 or 10% of total panel			X		30 days after quarter end		DMS
Member Services Report	Provide self-report on prior month's performance in the areas of call center abandonment, blockage rate and average speed of answer		X			By the 10th of Every Month		DMS
Access/Delivery Network								
Geo Access Networks Reports & Maps	Distribution and analysis of current provider network and beneficiaries		X			By the 15th of Every Month		DMS
Access Issues/Problems Identified During the Quarter and/or Remedial Action Taken	Provide specific information on the nature of any access problems identified and any plans or remedial action taken			X		30 days after quarter end		DMS

Listing of Providers Denied Participation	Provide a complete listing of providers that requested participation during the report period and were denied			X		30 days after quarter end		DMS
Subcontracting Issues/Monitoring Efforts	Provide overview of all monitoring efforts of all subcontractors			X		30 days after quarter end		DMS
Quality Assurance and Improvement								
Summary of QI Activities	Describe the quality assurance activities during the report period			X		30 days after quarter end		DMS
QI Work plan	Outlines scope of activities, goals, objectives and timelines for QAPI program			X		30 days after quarter end		DMS
Monitoring of Indicators, Benchmarks and Outcomes	Report should include progress in baseline data, sampling methods to validate used a comparison for QI plan and health outcomes				X		July 31st	DMS
Performance Improvement Projects	Progress and status updates of PIPs				X		July 31st	DMS

Utilization of Subpopulations and individuals with special healthcare needs	Discuss any issues during the report period related to members associated with populations and individuals with special health care needs			X		30 days after quarter end		DMS
Committee activities, including any decisions regarding quality and appropriateness of care	Provide a summary of the activities within Contractor and committees that met during the report period			X		30 days after quarter end		DMS
Satisfaction Survey(s)	Describe results of any satisfaction survey that was conducted during the report period				X		July 31st	DMS
Evidence-Based guidelines for practitioners	Report on assessment activities during the report period in development and distribution of practice guidelines for providers			X		30 days after quarter end		DMS
Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death	Provide summary of activities of these programs changes or trends including outreach and informative activities			X		30 days after quarter end		DMS

Overview of Activities	Provide summary of activities of these programs changes or trends and provide a summary of approved and denied EPSDT Special Services			X		30 days after quarter end		DMS
Credentialing and Recredentialing Activities During the Quarter	Summarize credentialing and re-credentialing activities			X		30 days after quarter end		DMS
Grievances/Appeals								
Grievance Activities During the Quarter	Provide of all member and provider grievances and appeals			X		30 days after quarter end		DMS
Appeal Activities During the Quarter	Provide of all member and provider grievances and appeals			X		30 days after quarter end		DMS
Trends or Problem Areas	Discuss any trends or problem areas identified in grievances or appeals and the effort to address any trends			X		30 days after quarter end		DMS
Budget Neutrality/Fiscal Impact								
Budgetary Issues for the Quarter	Provide discussion of budgetary issues including changes in appropriations, adjustments in the upper limit or etc			X		30 days after quarter end		DMS

Potential/Anticipated Fiscal Problems	Include a discussion of potential/ anticipated fiscal challenges and include plans on resolving them			X		30 days after quarter end		DMS
Utilization								
Enrollment Summary Report	(1/1-3/31 enrollment submitted 7/30, 1/1-6/30 submitted 10/30, 1/1-9/30 submitted 1/30 and 1/1-12/31 submitted 4/30.)			X		30 days after quarter end		DMS
Ambulatory Care by Age Breakdown	Provide utilization data during the report period				X		April 30th	DMS
Emergency and Ambulatory Care Resulting in Hospital Admission	Provide utilization data during the report period				X		April 30th	DMS
Emergency Care by ICD-9 Diagnosis	Provide utilization data during the report period				X		April 30th	DMS
Home Health Utilization	Provide utilization data during the report period				X		April 30th	DMS
Ambulatory Care by Provider Type and Category of Aid	Provide utilization data during the report period				X		April 30th	DMS
EPSDT Special Services	Provide utilization during the report period				X		April 30th	DMS
Pharmacy								
Top 50 Drugs - cost, number of prescriptions	Provide utilization data during the report period				X		April 30th	DMS

Top therapeutic classes based on Top 50 drugs - cost, number of prescriptions	Provide utilization data during the report period				X		April 30th	DMS
Pharmacy Utilization (# of Members, # of Rx, PMPM cost, Brand vs. Generic)	Provide utilization data during the report period				X		April 30th	DMS
Monitoring Activities Related to Utilization and Access to Care	Provide utilization data during the report period			X		30 days after quarter end		DMS
Utilization Trends/Patterns Identified During the Quarter	Provide utilization data during the report period			X		30 days after quarter end		DMS
Summary of Denials Rendered During the Quarter	Provide utilization data during the report period			X		30 days after quarter end		DMS
UM Call Statistics	Provide utilization data during the report period			X		30 days after quarter end		DMS
Systems								
Systems and Data Development Issues	Discuss the status of systems, data development and issues			X		30 days after quarter end		DMS

Claims Processing Timeliness/Encounter Data Processing	Provide status on the timeliness of encounter data reporting, processing of claims including steps taken to correct problems			X		30 days after quarter end		DMS
Other Activities								
Organizational Changes	Identify any organizational changes during the report period			X		30 days after quarter end		DMS
Administration Changes	Identify any administrative changes during the report period			X		30 days after quarter end		DMS
Innovations / Solutions	Provide information on additional or innovative program solutions during the report period			X		30 days after quarter end		DMS
Other	Provide any information relevant to the operation during the report period			X		30 days after quarter end		DMS
Expenditures Related to MCO's Operations	Provide business plan that outlines proposed annual expenditures			X		30 days after quarter end		DMS

DOI Claims	The current (as of 11-02) reporting requirement from DOI became effective for the reporting period beginning 7/1/02 and includes claims received within the quarter			X		180 days after quarter end		DOI and DMS
COB Savings	Provide report on insurance contractor has on file and pays claims accordingly		X			By the 15th of Every Month		DMS
Cost Avoidance Summary Savings (Medicare only)	Provide report for claims that have been denied due to Medicare		X			By the 15th of Every Month		DMS
Cost Avoidance Summary Savings (no Medicare)	Provide report for claims that have been denied due to other insurance		X			By the 15th of Every Month		DMS
Potential Subrogation	Provide reports for cases where the contractor's member has had an accident and there is a possible liable third party		X			By the 15th of Every Month		DMS
Claims Processing	Report from claims processing function in the format agreed upon		X			By the 15th of Every Month		DMS

Prior Authorization	Provide number and type of services both approved and denied in the format agreed upon		X			By the 15th of Every Month		DMS
Claims Processing Summary by Provider Type-Paid	Provide number of claims paid by provider in the format agreed upon		X			By the 15th of Every Month		DMS
Claims Processing Summary by Provider Type-Denied	Provide number of claims denied by provider with a reason for the denied claim in the format agreed upon		X			By the 15th of Every Month		DMS
Claims Processing Summary by Provider Type-Suspended	Provide number of claims suspended by provider with a reason for the suspended claim in the format agreed upon		X			By the 15th of Every Month		DMS
Claims Inventory	Provide number of claims by provider type which exceed processing timeliness standards defined by the department in the format agreed upon		X			By the 15th of Every Month		DMS
Encounter Data	Required to provide encounter records/transactions	X						DMS
Foster Care Report	Provide foster care case reports in the format agreed upon		X			By the 15th of Every Month		DMS

Guardianship Report	Provide guardianship case reports in format agreed upon		X			By the 15th of Every Month		DMS
Credentialed Providers Report	Provide number of provider applications received, credentialed, processed, enrolled and not enrolled/reason for termination		X			By the 15th of Every Month		DMS
Provider Enrollment Report	Electronically transmit provider enrollment information		X			By the 15th of Every Month		DMS
Provider Termination Report	Report should include any provider or subcontractor who engages in activities that result in suspension, termination or exclusion		X			By the 15th of Every Month		DMS
Provider Denial Report	Report should include any provider or subcontractor who is denied participation		X			By the 15th of Every Month		DMS
Provider Outstanding Accounts Receivables Report	Report should contain all outstanding accounts with an age of 180 days or older		X			By the 15th of Every Month		DMS

Member Program Violation Collections and Letters	Report should provide how much collected on all member cases whether begun internally or in court. Provide number of mailed letters, responses/results and collections		X			By the 15th of Every Month		DMS
Summary of Member EOB Report	Report should contain number of letters Contractor sent out, how many responses were received, actions taken and collections		X			By the 15th of Every Month		DMS
Lock-In Report	Report should contain number of members locked into PCP, pharmacy and hospital and provide year before lock in and year after paid amounts			X		30 days after quarter end		DMS
Algorithms Report	Report should contain number ran and results.		X			By the 15th of Every Month		DMS
Provider Fraud, Waste and Abuse Report	Report should contain all open cases and closed previous quarter cases and their status as of the date of the report			X		30 days after quarter end		DMS

Member Fraud, Waste and Abuse Report	Report should contain all open cases and closed previous quarter cases and their status as of the date of the report			X		30 days after quarter end		DMS
Quarterly Benefits Payment	Provider report summarizing Medicaid payments by category of service for each month during quarter			X		30 days after quarter end		DMS
Health Risk Assessments	Provide HRA's on new members, number completed, number not completed and number of refusals			X		30 days after quarter end		DMS
Provider Changes in Network Report	Report should contain providers in network accepting new member, not accepting members and panel size			X		30 days after quarter end		DMS
Out of Network Utilization by Members	Provide report for within MCO region providers not participating with Contractor's provider network and those providers providing services outside of the MCO region			X		30 days after quarter end		DMS

Status of all Subcontractors	Provide an overview of all monitoring efforts of all subcontractors/vendors			X		30 days after quarter end		DMS
Member TPL Resource Information (format)	Provide report of other insurance information on contractor's members		X			By the 15th of Every Month		DMS
QAPI Program Description	Provide QAPI program description documents				X		July 31st	DMS
Quality Improvement Plan and Evaluation	Provide details the annual review and include review of completed and continuing QI activities				X		July 31st	DMS
Outreach Plan	Provide both EPSDT and non-EPSDT outreach activities, frequency, responsible staff, activities and evaluated				X		July 31st	DMS
DMS copied on Report to Management of any changes in Member Services function to improve quality of care provided or method of delivery	Provide report to improve Member Services functions in providing quality of care provided and delivered				X		July 31st	DMS

Absent parent cancelled court order information	Provide report from court order information generated from data matches the Division of Child Support Enforcement/Department in the format agreed upon				X		July 31st	DMS
List of the Members participating with the Quality Member Access Advisory Committee	Provide list of members participating on committee				X		July 31st	DMS
Performance Improvement Projects (PIP) Proposal	Provide project proposal for clinical and non-clinical focus areas				X		September 1st	DMS
Abortion Procedure Report	Provide report by quarter on claims paid with abortion procedure code and be submitted with appropriate documentation			X		30 days after end of quarter		DMS
Performance Improvement Project Measurement	Provide project measurements for clinical and non-clinical focus areas				X		September 1st	DMS
CMS-416 (EPSDT)	Provide reports on EPSDT services including the current CMS-416 format				X		March 15th	DMS

Member Survey(s)	Provide survey instruments for review and a copy of all results				X		August 31st	DMS
Provider Survey(s)	Provide survey instruments for review and a copy of all results				X		August 31	DMS
Submit the final audited HEDIS report to DMS and NCQA	Provide final auditor's report issued by NCQA certified audit and data submission tool				X		August 31st	DMS
Behavioral Health								
Member Receiving Behavioral Health Services								
Number of Unduplicated Adults and Children/Youth	Provide monthly and year-to-date reports of the unduplicated number of adults and the unduplicated number of children/youth who have received a mental health and/or a substance abuse service** (to be reported separately unless delivered as an integrated service)		X			By the 15th of Every Month		DBHDID

Number of Unduplicated Pregnant and Postpartum Members	Provide monthly and year-to-date reports of the unduplicated number of pregnant and postpartum (60 days) patients who have received substance abuse services		X			By the 15th of Every Month		DBHDID
Number of Unduplicated of Intravenous Drug using Members	MCO to provide monthly and year-to-date reports of the unduplicated number of intravenous drug using patients who have received substance abuse services		X			By the 15th of Every Month		DBHDID
EPSDT and Behavioral Health Services	Provide EPSDT monthly and year-to-date reports for behavioral health services provided (by procedure code)		X			By the 15th of Every Month		DBHDID
Unduplicated Number and Percentage of Adults with SMI	Provide monthly and year-to-date reports of the unduplicated number and percentage of adults with SMI who are receiving peer support services		X			By the 15th of Every Month		DBHDID

Unduplicated Number and Percentage of Adults and Children/Youth with Mental Health and Substance Abuse Services	MCO to provide monthly and year-to-date reports of the unduplicated number and percentage of adults and the unduplicated number and percentage of children/youth of who have received *both* mental health *and* substance abuse services.		X			By the 15th of Every Month		DBHDID
Unduplicated Number of Children/Youth Receiving Impact Plus	Provide monthly and year-to-date reports of the unduplicated number of children/youth (up to age 21) who are assessed for IMPACT Plus covered service eligibility.		X			By the 15th of Every Month		DBHDID
Unduplicated Number of Children/Youth Receiving Impact Plus Prior Authorizations	Provide monthly and year-to-date reports of the unduplicated number of children/youth who receive services under IMPACT Plus eligibility, and the resulting services, by type and unit, that were prior authorized including the type and units of those prior authorized services that were rendered		X			By the 15th of Every Month		DBHDID

Unduplicated Number of Adults and Children/Youth Received Services under 907 KAR 3:110	MCO to provide monthly and year-to-date reports of the unduplicated number of adults and unduplicated number of children/youth who have received each of the following level of substance abuse services, as defined in 907 KAR 3:110: Prevention, Assessment, Outpatient, Intensive Outpatient, Residential and Case Management		X			By the 15th of Every Month		DBHDID
Pharmacy use and Cost for Adults and Children/Youth with Behavioral Health Diagnoses	MCO will provide monthly and year-to-date reports of all pharmacy use and cost for adults (18 +) and children/youth (up to age 21) with behavioral health diagnoses		X			By the 15th of Every Month		DBHDID
Pharmacy use and Cost for Children/Youth Received Impact Plus Services	MCO will provide monthly and year-to-date reports of all pharmacy use and cost for children/youth (up to age 21) who receive IMPACT Plus covered services		X			By the 15th of Every Month		DBHDID
Inpatient Psychiatric Hospitalization / Level I and II PRTFs - Admissions / Readmissions								

Unduplicated Number of Adults and Children/Youth Received PRTF - Level I and Level II	Provide monthly and year-to-date reports of the unduplicated number of adults and the unduplicated number children/youth who have received inpatient psychiatric hospitalization, psychiatric residential treatment (PRTF- Level I and Level II) and residential substance abuse treatment. This report shall include length of stay and "discharged to" information and must delineate those placed out-of-state. This report also shall include placements covered by the insurer (including KCHIP and EPSDT) and those covered by other payor sources		X			By the 15th of Every Month		DBHDID
Unduplicated Number and Percentage of Adults and Children/Youth Readmitted to PRTF	Track and report quarterly and year-to-date the number and percentage of children/youth and adults who have been readmitted within 30 days and within 180 days to an inpatient psychiatric setting and/or PRTF		X					DBHDID
Services Provided								
Behavioral Health Services Provided by Procedure Code	Provide monthly and year-to-date reports of behavioral health (mental health and substance abuse) by procedure code. The report should delineate number of unduplicated members receiving the service, units of service and paid amount of claim (by procedure code)		X			By the 15th of Every Month		DBHDID
Member Best Practices Outcomes								

Unduplicated Number and Percentage of Adults with SMI	Provide monthly and year-to-date reports of the unduplicated number and percentage of adults with SMI who live in independent, permanent housing		X			By the 15th of Every Month		DBHDID

Unduplicated Number and Percentage of Adults with SMI and Children/Youth with SED Received with Co-occurring Mental Health and Substance Abuse Disorders	Provide monthly and year-to-date reports of the unduplicated number and percentage of adults with SMI and children/youth with SED who received Assertive Community Treatment, Supported Employment, Supportive Housing, Family Psycho education, Integrated treatment for co-occurring mental health and substance abuse disorders, Illness Management/Recovery, or Medication Management		X			By the 15th of Every Month		DBHDID
Unduplicated Number and Percentage of Children/Youth with SED Therapy or Family Functional Therapy	Provide monthly and year-to-date reports of the unduplicated number and percentage of children/youth with SED who received Therapeutic Foster Care, Multisystem Therapy or Family Functional Therapy		X			By the 15th of Every Month		

Unduplicated Number and Percentage of Children/Youth with SED who were assessed for Trauma History	Provide monthly and year-to-date reports of the unduplicated number and percentage of children/youth with SED who were assessed for trauma history		X			By the 15th of Every Month		
Unduplicated Number of Adults and Children/Youth of their Caregivers Received Peer Support Service	Provide monthly and year-to-date reports of the unduplicated number of adults and children/youth or their caregivers who received a Peer Support Service from an individual credentialed by the DBHDID		X			By the 15th of Every Month		DBHDID
Member Access								
Unduplicated Number and Percentage of Pregnant and Post-partum women with Substance use Disorders Received First Treatment within 48 hours	Report monthly and year-to-date on the number and percentage of pregnant and post-partum women with substance use disorders who receive their first treatment visit within 48 hours of initial request for services		X			By the 15th of Every Month		DBHDID
Continuity of Care								

Unduplicated Number and Percentage of Children/Youth Discharged from PRTF	Report quarterly and year-to-date on number and percentage of children/youth (under 21) and adults (18 +) discharged from an inpatient psychiatric facility or PRTF who participate in an outpatient visit within seven (7) and 14 days of discharge		X			By the 15th of Every Month		DBHDID
Unduplicated Number and Percentage of Children/Youth Discharged from a Residential Substance Abuse Treatment Program	Report quarterly and year-to-date on number and percentage of youth (under 21) and adults (18 +) discharged from a residential substance abuse treatment program who participate in an outpatient visit within seven (7) and 14 days of discharge		X			By the 15th of Every Month		DBHDID
Member Satisfaction								
Mental Health Statistics Improvement Project (MHSIP) Adult Survey	Provide annual report on the results of the administration of the Mental Health Statistics Improvement Project (MHSIP) adult survey. Results should be displayed as the number of individuals surveyed and the percentage reporting positively in the following seven domains: General satisfaction, Access, Quality / Appropriateness, Participation in Treatment Planning, Outcomes, Social Connectedness and Functioning				X		August 31st	DBHDID

Administration of the Youth Services Satisfaction Caregiver (YSS-F)	Provide annual report on the results of the administration of the Youth Services Satisfaction Caregiver (YSS-F) survey for children/youth. Results should be displayed as the number of individuals surveyed and the percentage rating positively in the following seven domains: General satisfaction, Access, Quality / Appropriateness, Participation in Treatment Planning, Outcomes, Social Connectedness and Functioning				X		August 31st	DBHDID
Interface with Criminal Justice / Education								
Interface with Primary Care / Physical Health								
Unduplicated Number of Adults and Children/Youth with Behavioral Health Diagnosis's with PCP	Provide quarterly and year-to-date reports of the number of children/youth and adults, with behavioral health diagnoses, who have a known Primary Care Provider (PCP)			X		30 days after quarter end		DBHDID

Unduplicated Number of Children/Youth with Behavioral Health Diagnoses Received Annual Wellness Check/Health Exam	Provide quarterly and year-to-date reports of the number of children/youth (up to age 21) and adults (18 +) with behavioral health diagnoses who receive annual wellness check/annual physical health exams			X		30 days after quarter end		DBHDID
Unduplicated Number of Adults and Children/Youth General Behavioral Health Diagnosis and Chronic Physical Health Diagnosis	Provide quarterly and year-to-date reports of the number of children/youth (up to age 21) and adults (general behavioral health and with SMI designation) with both an Axis I behavioral health diagnosis(as) and a chronic (physical) health diagnosis(as). *Exclusions are permitted in instances where the behavioral health diagnosis is well documented as directly attributable to the physical health condition*			X		30 days after quarter end		DBHDID
Unduplicated Number of Adults and Children/Youth with Regular use of Tobacco Products	Provide annual report of the number of children/youth (up to age 18) and adults (18+) who report regular use (once a week or greater) of tobacco products (all types).				X		August 31	DBHDID

Unduplicated Number of Adults and Children/Youth Screened for Substance Use Disorder in Physical Care Setting	Provide quarterly and year-to-date report on the number of children/youth (up to age 18) and adults (18+) who are screened for a substance use disorder in a physical care setting (including ER, primary care, specialized care, other)			X		30 days after quarter end		DBHDID

Appendix M

Program Integrity Requirements

I. Organization

A. The Contractor's Program Integrity Unit (PIU) shall be organized so that:

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

II. Function

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

A. The Contractor's PIU shall be responsible for:

1. Preventing Fraud, Waste and Abuse by identifying vulnerabilities in

the Contractor's program including identification of member and provide Fraud, Waste and Abuse by and taking appropriate action including but not limited to the following:

- Recoupment of overpayments;
- Changes to policy;
- Dispute resolution meetings; and
- Appeals.

2. Proactively detecting incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithm, investigations and record reviews;
3. Determining the factual basis of allegations through investigation concerning fraud or abuse made by Members, Providers and other sources;
4. Initiating appropriate administrative actions to collect overpayments, deny or suspend payments that should not be made;
5. Referring potential Fraud, Waste and Abuse cases to the OIG (and copying DMS) for preliminary investigation and possible referral for civil and criminal prosecution and administrative sanctions;
6. Initiating and maintaining network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside groups;
7. Making and receiving recommendations to enhance the Contractor ability to prevent, detect and deter Fraud, Waste or Abuse;
8. Providing prompt response to detected offenses and developing corrective action initiatives relating to the Contractor's contract;

(i) Providing for internal monitoring and auditing of Contractor and its subcontractors; and supply the department with quarterly reports on the activity and ad hocs as necessary;

9. Being subject to on-site review and fully complying with requests from the department to supply documentation and records; and
10. Creating an account receivables process to collect outstanding debt from members or providers and providing monthly reports of activity and collections to the department.

B. The Contractor's PIU shall:

1. Conduct continuous and on-going reviews of all MIS data including, Member and Provider Grievances and appeals, for the purpose of identifying potentially fraudulent acts;
2. Conduct regularly scheduled post-payment audits of provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Contractor, the Department and OIG;
3. Conduct onsite and desk audits of providers and report the results to the Department, including any overpayments identified;

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

III. Patient Abuse

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

IV. Complaint System

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

A. The process shall contain the following:

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

law enforcement agencies that received the OIG referral;

11. Upon approval of the Department, Contractor shall suspend provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;
12. Upon completion of the PIU's preliminary investigation, the PIU should provide the Department and OIG a copy of their investigative report, which should contain the following elements:
    - Name and address of subject;
    - Medicaid identification number;
    - Source of complaint;
    - The complaint/allegation;
    - Date assigned to the investigator;
    - Name of investigator;
    - Date of completion;
    - Methodology used during investigation;
    - Facts discovered by the investigation as well as the full case report and supporting documentation;
    - All exhibits or supporting documentation;
    - Recommendations as considered necessary, for administrative action or policy revision;
    - Overpayment identified, if any, and recommendation concerning collection;
13. The Contractor's PIU shall provide OIG and DMS a quarterly member and provider status report of all cases including actions taken to implement recommendations and collection of overpayments;
14. The Contractor's PIU shall maintain access to a follow-up system, which can report the status of a particular complaint or grievance process or the status of a specific recoupment; and
15. The Contractor's PIU shall assure a Grievance and appeal process for Members and Providers in accordance with 907 KAR 1:671 and 907 KAR 1:563.

V. Reporting

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

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

The Contractor's PIU shall report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the

Department and OIG.

A. The Contractor is required to report the following data elements to the Department and the OIG on a quarterly basis, in an excel format:

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

VI. Availability and Access to Data

A. The Contractor shall:

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

3. Backup, store and be able to recreate reported data upon demand for the Department and the OIG;
4. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department or OIG, or other authorized federal or state agency; and shall provide access to 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;
5. Produce records in electronic format for review and manipulation by the Department and the OIG;
6. Allow designated Department staff read access to ALL data in the Contractor's MIS systems; and
7. Provide all contracted rates for providers upon request.

The Contractor's PIU shall have 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.

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

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

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

Appendix N

Performance Improvement Projects

The Performance Improvement Projects (PIPs) shall include one project (1) relating to physical health, one (1) project relating to behavioral health, and one (1) project relating to a statewide care or services issue. Following is a table which identifies the four (4) clinical care and non-clinical services topics which will be implemented Year One of the Contract as well as justification (reasons) for selecting these topics.

A. The topic relates to clinical care and non clinical services and represents a national and/or statewide health issue;

B. There are current guidelines/standards available to guide the development/implementation of a PIP;

C. There are identifiable measures for performance improvement (HEDIS or claims data); and

D. The topic is associated with historical over- or underutilization of Medicaid Services.

TOPIC		JUSTIFICATION (REASON)				
	Clinical Care or Non-clinical Service	National &/or State Care or Services Burden	Performance Guidelines/ Standards of Care are Available	HEDIS or Other Measures for Performance are Available	Assoc with Under – &/or Over utilization (High Costs)	Other Reasons
Access to & Availability of Services	Non-clinical Svc.	YES	YES	YES	YES	The *Ensuring Access to Care in Medicaid under Health Reform* report **** cited concerns regarding the expansion of Medicaid eligibility under the 2010 ACA & movement of states toward using Contractors for management of health & healthcare costs of Medicaid Members. Concerns were also expressed

						regarding Medicaid's comprehensive benefits & ensuring access to provider/delivery systems equipped to serve low-income populations with complex health needs. Additionally, 1)Access to/availability of Medicaid participating primary care providers & specialists is a major concern, as reimbursement levels are reduced due to state Medicaid budget deficits & demands on state resources increase. 2)Contractors express concerns regarding the "churning," which results from short Medicaid eligibility/enrollment periods, as this is viewed as key obstacle in managing care & incompatible with efforts to manage chronic conditions & prevent disruptions in care.
Depression	Clinical Care	YES	YES	YES	YES	*The State of Health Care Quality* report** indicated that depression affects 15 million Americans, & if untreated, can lead to other physical/mental health conditions. The American Psychiatric Association recommends use of antidepressant & behavioral therapies (at the primary care level) to treat depression. Additionally, in 2009, 49.6% of Medicaid Members, 18 years of age/older diagnosed with a new episode of major depression, were treated with antidepressant medication for a specified period of time, as compared to 62.9 % of individuals 18 years of age/older who were covered under commercial HMO health plans.

Emergency Department (ED) Use Management	Clinical Care	YES	NO	YES	YES	The data on emergency room utilization of FFS KY Medicaid claims for ED visits in CY 2008 indicated that the major difference between "high fliers" (having 12 or more ER visits/yr) & "single timers" (having one visit/yr), is that high fliers are most over-represented in 3-digit primary diagnosis codes for abdominal symptoms, migraines & back conditions, which may be effectively treated (on a primary care level). Additionally, of FFS Medical claims for ED services provided in SFY 2010, indicated that a total of $151,897,739 was spent on illnesses/conditions such as upper respiratory infection, otitis media, acute pharyngitis, viral infection and lumbago.
Screenings for Breast Cancer, Cervical Cancer, & Chlamydia	Clinical Care	YES	YES	YES	YES	The *Aggregate Medicaid Plan Report** for CY 2009, indicated that the KY Medicaid Average rate of mammograms performed (45%) & Medicaid Average rate of PAP tests performed (57%) were lower, as compared to the KY Average rate of mammograms performed (68%) and KY Average rate of PAP tests performed (72%). Additionally, *The State of Health Care Quality* report** indicated that: 1)Breast cancer is one of the most common forms of cancer in American women, accounting for the deaths of 40, 170 women in 2009. In that same year, 52.4% of Medicaid women 50-69 years of age were screened by mammography, as compared to 71.3 % of women 50-69 years of age covered under Commercial HMO health plans.

						2)As one of the most treatable cancers, cervical cancer is the second most common cancer worldwide & 10th leading cause of cancer in females. In 2009, 65.8% of Medicaid women 21 to 64 years of age received PAP tests, as compared to 77.3% of women 21–64 years of age covered under Commercial HMO plans. 3)Chlamydia is a sexually transmitted disease that may have serious consequences (e.g., HIV, syphilis, reproductive health conditions). Although screening rates for Chlamydia in 2009 are higher in Medicaid populations (61.6%), as compared to Commercial HMO rates (45.4%) according to this report, the screening is not complicated & can save $45 annually for every woman screened.

References

**Aggregate Medicaid Plan Report, Select Preventive Care Measures, January 09 – December* 09 distributed by The Kentuckiana Health Collaborative in 2010.

***The State of Health Care Quality 2010,* published by the National Committee for Quality Assurance in 2011.

*****Ensuring Access to Care in Medicaid under Health Reform,* Report #8187, published by Kaiser Family Foundation in May 2011.

Appendix O

Health Outcomes, Indicators, Goals and Performance Measures

A goal of the Medicaid Program is to improve the health status of Medicaid recipients. Statewide health care outcomes, health indicators, and goals have been targeted and designated by the Department in collaboration with the Departments for Public Health (DPH) and Behavioral Health, Developmental and Intellectual Disabilities. Federal Medicaid Managed Care regulations, 438.24 (C) (1) and (C) 2 Performance Measurement, require that the Contractor measure and report to the State its performance, using standard measures required by the State and/or submit to the State data, specified by the State that enables the State to measure the Contractor's performance.

In accordance with this, the Department has established a set of Medicaid Managed Care Performance Measures. The measure set was originally designed to align with the *Healthy Kentuckians 2010 Goals. Healthy Kentuckians* is the state's commitment to national preventive initiative, *Healthy People 2010,* with the overarching goals to increase years of healthy life and eliminate health disparities and includes objectives and targets set to meet the needs of Kentuckians. The document includes ten leading health indicators with related goals and objectives. Select indicators, goals and objectives that are the basis of the Performance Measures are displayed in the table below.

Other Performance Measures are derived from the managed care Healthcare Effectiveness Data and Information Set (HEDIS®)[4] set, which are reported by managed care organizations nationally and have national benchmarks for comparison of performance. Performance Measures have also been developed collaboratively by the Department and the EQRO based on key areas of interest of the Department. Together, the measures address the access to, timeliness of, and quality of care provided to children, adolescents enrolled in Managed Care; and focus on preventive care, health screenings, prenatal care, as well as special populations (adults with hypertension, children with special health care needs (CSHCN).

[4] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Healthy Kentuckians Leading Health Indicator(s)[5]	Healthy Kentuckians Goals	Health Kentuckians Objectives[6]	Related Medicaid Managed Care Performance Measure(s)
Physical Activity and Fitness Nutrition	▪ Improve the health, fitness, and quality of life of all Kentuckians through the adoption and maintenance of regular, daily physical activity. ▪ To promote health and reduce chronic disease risk, disease progression, debilitation, and premature death associated with dietary factors and nutritional status among all people in Kentucky.	▪ Reduce overweight to a prevalence of no more than 25 percent among Kentuckians ages 18 and older. ▪ Reduce the percentage of Kentuckians age 18 and older who are either overweight or obese. ▪ Increase to at least 35% the proportion of Kentuckians ages 18 and over who engage in moderate physical activity 5 or more days per week. ▪ Decrease the percentage of Kentuckians reporting no leisure time physical activity (by BMI category, i.e., normal weight,	▪ Height/Weight/BMI Assessment and Assessment/ Counseling for Nutrition and Physical Activity for Adults[7] ▪ Height/Weight/BMI Assessment and Assessment/ Counseling for Nutrition and Physical Activity for Children and Adolescents[8]

[5] See the Healthy Kentuckians 2010 Mid-Decade Review for full details on all indicators, goals, and objectives. Available at: http://chfs.ky.gov/dph/hk2010MidDecade.htm.

[6] Stated State and National Performance Target goals are for reference only and reflect the Healthy Kentuckians goals, and do not apply to health plan contract requirements.

[7] The performance measure for this goal will follow a combination of the HEDIS measure specifications for Adult BMI assessment and State-specific numerator(s).

[8] The performance measure for this goal will follow a combination of the HEDIS measure specifications for Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescent s and State-specific numerator(s).

Healthy Kentuckians Leading Health Indicator(s)[5]	Healthy Kentuckians Goals	Health Kentuckians Objectives[6]	Related Medicaid Managed Care Performance Measure(s)
		overweight, obese class I, obese class II, obese class III). ▪ To increase to at least 24 percent the proportion of young people in grades 9-12 who engage in moderate physical activity for at least 30 minutes on five or more of the previous seven days. ▪ Increase to at least 50 percent the prevalence of healthy weight (defined as a body mass index (BMI) greater than 19.0 and less than 25.0) among all people aged 20 and older. ▪ Reduce to less than 15 percent the prevalence of BMI at or above 30.0 among people aged 20 and older. ▪ Reduce to 5 percent or less the prevalence of overweight and obesity (at or above the sex and age-specific 95th percentile of BMI from the revised NCHS/CDC growth charts) in children	

Healthy Kentuckians Leading Health Indicator(s)[5]	Healthy Kentuckians Goals	Health Kentuckians Objectives[6]	Related Medicaid Managed Care Performance Measure(s)
		(aged 1 – 5 and 6 – 11) and adolescents (aged 12 – 19). ▪ Increase to at least 40 percent the proportion of people age 2 and older who meet the Dietary Guidelines' minimum average daily goal of at least five servings of vegetables and fruits.	
Heart Disease and Stroke	Enhance the cardiovascular health and quality of life of all Kentuckians through improvement of medical management, prevention and control of risk factors, and promotion of healthy lifestyle behaviors.	▪ To increase to at least 85 percent the proportion of adults who have had their blood cholesterol checked within the preceding five years. ▪ Reduce heart disease deaths to no more than 250 deaths per 100,000 people (age adjusted to the year 2000 standard). ▪ To decrease to at least 20 percent the proportion of adult Kentuckians with high blood pressure. ▪ Reduce heart	▪ Cholesterol Screening for Adults ▪ HEDIS Controlling High Blood Pressure[9]

[9] The performance measure for this goal will follow the HEDIS measure specifications for Controlling High Blood Pressure.

Healthy Kentuckians Leading Health Indicator(s)[5]	Healthy Kentuckians Goals	Health Kentuckians Objectives[6]	Related Medicaid Managed Care Performance Measure(s)
		disease deaths to no more than 250 deaths per 100,000 people (age adjusted to the year 2000 standard).	
Tobacco Use	▪ Reduce the burden of tobacco-related addiction, disease, and mortality, thereby improving the health and well being of adults and youth in Kentucky. This includes decreasing tobacco use among adults, pregnant women, youth, and disparate populations, eliminating exposure to secondhand smoke, and building capacity in communities for tobacco prevention and cessation.	▪ Increase to 95 percent the proportion of patients who receive advice to quit smoking from a health care provider. ▪ Increase to 32 percent the proportion of young people in grades 9 to 12 who have never smoked. ▪ Reduce the proportion of high school and middle school students who think smoking cigarettes makes young people look cool or fit in. ▪ Increase to 100 percent the proportion of high school students who think secondhand smoke is harmful. ▪ Reduce cigarette smoking among pregnant women to a prevalence of no more than 17 percent. ▪ Of new mothers	▪ Adolescent Screening/ Counseling: Tobacco Use ▪ Prenatal Risk Assessment, Counseling and Education: Tobacco Use

Healthy Kentuckians Leading Health Indicator(s)[5]	Healthy Kentuckians Goals	Health Kentuckians Objectives[6]	Related Medicaid Managed Care Performance Measure(s)
		who smoked in the first three months before becoming pregnant, increase the percentage who abstained from using tobacco during their pregnancy.	
Oral health [7]	To improve the health and quality of life for individuals and communities by preventing and controlling oral disease and injuries, and to improve access to oral health care for all Kentuckians.	▪ Increase to at least 70 percent the proportion of children ages 6, 7, 12, and 15 who have participated in an oral health screening, including those who have been referred, and those who have received the appropriate follow-up.	▪ HEDIS Annual Dental Visit[10]
Access to quality health services	Improve access to a continuum of comprehensive, high quality health care using both the public and private sectors in Kentucky.	▪ Increase to at least 90 percent the proportion of people who have a specific source of ongoing primary care. ▪ Reduce by 25 percent the number	▪ HEDIS Well Child Visits in the First 15 Months: 6+ visits[11] ▪ HEDIS Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life

[10] The performance measure for this goal will follow the HEDIS measure specifications for Annual Dental Visit.

[11] The performance measures for this goal will follow the HEDIS measure specifications for Well Child Visits 15 months (6+ visits), Well Child Visits 3rd, 4th, 5th & 6th Years of Life, and Adolescent Well-Care Visits, and Children's and Adolescents' Access to PCPs.

Healthy Kentuckians Leading Health Indicator(s)[5]	Healthy Kentuckians Goals	Health Kentuckians Objectives[6]	Related Medicaid Managed Care Performance Measure(s)
		of individuals lacking access to a primary care provider in underserved areas.	▪ HEDIS Adolescent Well Care ▪ HEDIS Children's Access to PCP's
Adolescent Screening/ Counseling: Tobacco Use[12], Alcohol/Substance Use, Sexual Activity, and/or Mental Health Assessment			
Tobacco Use Substance Abuse Alcohol Abuse	To increase abstinence from substances while reducing experimentation, use and abuse, especially among Kentucky's youth, thereby reducing the consequences -- violence, crime, illness, death and disability -- that result from abuse of substances at d harm to individuals and society.	▪ Increase the proportion of 8th grade students who report strong disapproval for use of tobacco, alcohol, and other drugs to: tobacco, 60 percent; alcohol, 65 percent; marijuana, 85 percent, and other drugs 98 percent. ▪ Increase the proportion of 8th grade students who report that none of their friends use substances to: tobacco: 70 percent; alcohol: 70 percent; marijuana: 90 percent, and other drugs: 95 percent. ▪ Increase the proportion of 8th grade students who perceive great risk of personal harm and/or trouble associated with	Adolescent Screening/ Counseling: Tobacco, Alcohol, and Substance Use

[12] See Healthy Kentuckians Indicator for Tobacco Use for additional details on this numerator.

Healthy Kentuckians Leading Health Indicator(s)[5]	Healthy Kentuckians Goals	Health Kentuckians Objectives[6]	Related Medicaid Managed Care Performance Measure(s)
		regular use of substances: tobacco: 50 percent, alcohol: 35 percent, and marijuana: 80 percent. ▪ Increase the percentages of 8th grade students who report having never used tobacco, alcohol, and other drugs: tobacco: 65 percent; alcohol: 65 percent; marijuana: 90 percent; cocaine: 98 percent.	
Family Planning Sexually Transmitted Diseases	A society where healthy sexual relationships free of infection is the standard.	▪ Reduce pregnancies among females ages 15-17 to no more than 20 per 1,000 adolescents. ▪ Increase by at least 10 percent the proportion of sexually active individuals, ages 15-19, who use barrier method contraception with or without hormonal contraception to prevent sexually transmitted disease and prevent pregnancy. ▪ To increase to at least 68 percent the number of sexually active, unmarried	Adolescent Screening/ Counseling: Sexual Activity

Healthy Kentuckians Leading Health Indicator(s)[5]	Healthy Kentuckians Goals	Health Kentuckians Objectives[6]	Related Medicaid Managed Care Performance Measure(s)
		high school-aged youth who used a latex condom at last sexual intercourse.	
Mental Health Screening	Improve the mental health of all Kentuckians by ensuring appropriate, high-quality services informed by scientific research to those with mental health needs.	▪ Reduce by half the proportion of Kentucky adolescents who report considering or attempting suicide during the past year.	Adolescent Screening/ Counseling: Mental Health
Environmental Health	Health for all through a healthy environment.	▪ Increase the number of abatement permits for lead housing projects to 115 per grant fiscal year.	HEDIS Lead Screening in Children[13]
Access to Quality Health Services	Improve access to a continuum of comprehensive, high quality health care using both the public and private sectors in Kentucky.	▪ Increase to at least 90 percent the proportion of people who have a specific source of ongoing primary care.	Children with Special Health Care Needs (CSCHN)
Disability and Secondary Conditions	Promote health and prevent secondary conditions among persons with disabilities, including eliminating disparities between	▪ Ensure that 100 percent of persons with a developmental disability who receive services from the state	

[13] The performance measure for this goal will follow the HEDIS measure specifications for Lead Screening in Children.

Healthy Kentuckians Leading Health Indicator(s)[5]	Healthy Kentuckians Goals	Health Kentuckians Objectives[6]	Related Medicaid Managed Care Performance Measure(s)
	persons with disabilities and the U.S. population.	receive a yearly physical examination. ▪ Ensure that 100 percent of persons with a developmental disability who receive services from the state receive a dental examination every six months.	

Medicaid Managed Care Performance Measures

The Department, in collaboration with the EQRO, have developed a set of measures that are clinically sound, consistent with Healthy Kentuckians goals, and that complement the Managed Care Organizations' quality improvement goals. Annually, the Department, with input from the Contractor and the EQRO, will determine measures that should be retired, revised, rotated or determine if new measures should be developed. The Contractor is expected to demonstrate, through repeat measurement of the quality indicators, meaningful improvement in performance relative to the baseline measurement. Meaningful improvement shall be defined by: 1) reaching a prospectively set benchmark, or 2) improving performance and sustaining that improvement. The specific performance targets and timeframes are to be determined by the Department with input from the Contractor and EQRO. Annually, the non-HEDIS® measures shall be validated by the EQRO and the Contractor shall submit all data, documentation, etc., used to calculate the measures. Below is the current list of performance measures. Full specifications for calculating and reporting the non-HEDIS measures will be provided to the Contractor.

Kentucky Medicaid Managed Care Performance Measures			
Measure Name	**HEDIS/State-specific/Both**	**Admin/Hybrid**	**Baseline Measurement Period**
Adult BMI, Nutritional Screening/Counseling, Physical Activity Counseling, Height and Weight	Both	Hybrid/Medical Record Review	TBD
Adult Cholesterol Screening	HK	Administrative	TBD
Controlling High Blood Pressure	HEDIS	Hybrid	TBD
Prenatal Risk Assessment Counseling and Education	State-specific	Hybrid/Medical Record Review	TBD
BMI, Nutritional Screening/Counseling, Physical Activity Counseling, Height and Weight for Children and Adolescents	Both	Hybrid/Medical Record Review	TBD
Annual Dental Visit	HEDIS	Administrative	TBD
Lead Screening	HEDIS	Hybrid	TBD
Adolescent	State-specific	Hybrid	TBD

Screening/Counseling			
EPSDT Hearing Assessments	State-specific	Administrative	TBD
EPSDT Vision Assessment	State-specific	Administrative	TBD
Well Child 15 months	HEDIS	Administrative	TBD
Well Child Ages 3-6	HEDIS	Administrative	TBD
Adolescent Well Care Visits	HEDIS	Administrative	TBD
Children's and Adolescent's to PCPs	HEDIS	Administrative	TBD
Children with Special Health Care Needs (CSHCN)	State-specific		TBD

Appendix P

Business Associates Agreement

This Business Associate Agreement ("Agreement"), effective on this the ____ day of _____,20___, ("Effective Date"), is entered into by and between _____ (the "Business Associate") and _____, with an address at _____ (the "Covered Entity") (each a "Party" and collectively the "Parties").

The Business Associate is a _____. The Covered Entity is the executive agency of the Commonwealth of Kentucky vested with the authority to administer the ([Kentucky Medical Assistance Program (hereinafter the "Medicaid Program"), in accordance with the requirements of Title XIX of the Social Security Act (42 U.S.C. §1396 *et. seq.*) and KRS Chapter 205] or [Cabinet for Health and Family Services, Department for Behavioral Health, Developmental and Intellectual Disabilities, Kentucky Correctional Psychiatric Center ("KCPC") vested as a licensed hospital with the authority to administer care to patients as stated in KRS Chapter 216B], etc.). The Parties entered into a Master Contract _____ (the "Contract") on the ___ day of _____, 20___, under which the Business Associate may use and/or disclose Protected Health Information in its performance of the Services described in the Contract. This Agreement sets forth the terms and conditions pursuant to which Protected Health Information that is provided by Covered Entity to Business Associate, or created or received by the Business Associate from or 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 their Contract and after its termination. The Parties agree as follows:

WITNESSETH:

WHEREAS, 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; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services has issued regulations modifying 45 CFR Parts 160 and 164 (the "HIPAA Privacy Rule"); and

WHEREAS, the Parties wish to enter into or have entered into an arrangement whereby the Business Associate will provide certain services to the Covered Entity, and, pursuant to such arrangement, Business Associate may be considered a "business associate" of the Covered Entity as defined in the HIPAA Privacy Rule; and

WHEREAS, Business Associate may have access to Protected Health Information (as defined below) in fulfilling its responsibilities under the Contract.

THEREFORE, in consideration of the Parties' continuing obligations under the Contract, the Parties agree to the provisions of this Agreement in order to address the requirements of the HIPAA Privacy Rule and to protect the interests of both Parties.

1. DEFINITIONS

Unless otherwise specified in this Agreement, all capitalized terms used in this Agreement not otherwise defined in this Agreement shall have the meanings established for purposes of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (collectively, "HIPAA") and ARRA (as defined below), as each is amended from time to time.

2. PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

2.1 Services. Pursuant to the Contract, Business Associate provides services ("Services") for the Covered Entity that involve the use and/or disclosure of Protected Health Information. Except as otherwise specified herein, the Business Associate may make any and all uses and/or disclosures of Protected Health Information necessary to perform its obligations under the Contract, provided that such use would not violate the Privacy and Security Regulations if done by Covered Entity or the minimum necessary policies and procedures of HIPAA. All other uses not authorized by this Agreement are prohibited. Moreover, Business Associate may disclose Protected Health Information 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 or Security Regulations if done by Covered Entity or the minimum necessary policies and procedures of HIPAA.

2.2 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 uses are permitted under state and federal confidentiality 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 CFR §164.501 or (ii) the Business Associate has received from the third party written assurances regarding its confidential handling of such Protected Health Information as required under 45 CFR §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.

c. Notwithstanding anything to the contrary contained herein, the parties understand and agree that inasmuch as may be necessary to perform its services under the Contract, Business Associate shall be permitted to use, access, disclose and transfer PHI.

3. RESPONSIBILITIES OF THE PARTIES WITH RESPECT TO PROTECTED HEALTH INFORMATION

3.1 Responsibilities of the Business Associate. With regard 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, provided that such use or disclosure would not violate the Privacy and Security Regulations if done by the Covered Entity.

b. Shall, within five (5) business days, report to the designated Privacy Officer of the Covered Entity, in writing, any use and/or disclosure of the Protected Health Information of which Business Associate becomes aware that is not permitted or authorized by the Contract or this Agreement.

c. Establish procedures for mitigating, to the greatest extent possible, any deleterious effects from any improper use and/or disclosure of Protected Health Information that the Business Associate reports to the Covered Entity.

d. Use appropriate administrative, technical and physical safeguards to maintain the privacy and security of the Protected Health Information and to prevent uses and/or disclosures of such Protected Health Information other than as provided for in this Agreement and in the Contract.

e. Require all of its subcontractors and agents that receive or use, or have access to, Protected Health Information under this Agreement to agree, in writing, to adhere to the same restrictions and conditions on the use and/or disclosure of Protected Health Information that apply to the Business Associate pursuant to this Agreement and the Contract.

f. Make available all records, books, agreements, policies and procedures relating to the use and/or disclosure of Protected Health Information to the Secretary of the Department for Health and Human Services for purposes of determining the Covered Entity's compliance with the Privacy Regulation.

g. Upon prior written request in accordance with the Contact, make available during normal business hours at Business Associate's offices all records, books, agreements, policies and procedures relating to the use and/or disclosure of Protected Health Information under this Agreement to the Covered Entity to determine the Business Associate's compliance with the terms of this Agreement.

h. Upon Covered Entity's written request but in no event less than ten (10) business days prior written notice, Business Associate shall provide to Covered Entity an accounting of each Disclosure of PHI made by Business Associate or its employees, agents, representatives, or subcontractors in accordance with 45 CFR §164.528. 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 in accordance with 45 CFR §164.528. Business Associate shall include in the accounting: (a) the 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 accounting under this section, Business Associate shall document the information specified in (a) through (d), above, and shall securely retain this documentation for six (6) years from the date of the Disclosure. To the extent that Business Associate maintains PHI in an Electronic Health Record, Business Associate shall maintain an accounting of Disclosure for treatment, payment, and health care operations purposes for three (3) years from the date of Disclosure. Notwithstanding anything to the contrary, this requirement shall become effective upon either of the following: (a) on or after January 1, 2014, if Business Associate acquired Electronic Health 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 of the Department for Health and Human Services.

i. Subject to Section 4.5 below, return to the Covered Entity or destroy, at the termination of this Agreement, the Protected Health Information in its possession and retain no copies (which for purposes of this Agreement shall mean without limitation the destruction of all backup tapes). However, in the event Business Associate is continuing to need access to or use of the Protected Health Information pursuant to other agreements, contracts, purchase orders or services rendered to the Covered Entity, this paragraph shall not apply.

j. Disclose to its subcontractors, agents, or other third parties, and request from the Covered Entity, only the minimum Protected Health Information necessary to perform or fulfill a specific function required or permitted hereunder.

k. Business Associate agrees to report to the Covered Entity any security incident of which it becomes aware involving the attempted or successful unauthorized access, use, disclosure, modification, or destruction of Covered Entity's electronic Protected Health Information or interference with systems operations in an information system that involves Covered Entity's electronic Protected Health Information within five (5) business days of Business Associate's knowledge. An attempted 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 but merely 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 (a "Material Attempt"); and (ii) continuously reviewing, updating and modifying its security measures to guard against unauthorized access to its systems, but rather requires notification only when a Material Attempt results in significant modifications to 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 it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by 45 CFR part 164.308/310/312 & 164.314.

m. Business Associate agrees that any EPHI it acquires, maintains 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 guidance from the Secretary of the Department of Health and Human Services (DHHS) promulgated under ARRA.

n. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate safeguards to protect it as required by 45 CFR part 164.308/310/312 & 164.314.

o. Within five (5) business days of Business Associate's knowledge, the Business Associate agrees to notify the Covered Entity of any breach of unsecure PHI, as that term is defined in the ARRA and any subsequent regulations and/or guidance from the Secretary of DHHS, caused by Business Associate or any Business Associate agent or subcontractor performing under the Contract. Notice of such a breach shall include the identification of each individual whose

unsecured protected health information has been, or is reasonably believed by the business associate to have been, accessed, acquired, or disclosed during such breach. Business Associate further agrees to make available in a reasonable time and manner any information needed by Covered Entity to respond to individuals' inquiries regarding said breach.

p. In the event of a breach of unsecured PHI caused by Business Associate or any Business Associate agent or subcontractor performing under this Agreement, Business Associate shall pay for the reasonable and actual costs associated with notifications required pursuant to 42 U.S.C. §17932 and 45 C.F.R. Parts 160 & 164 subparts A, D & E as of their respective Compliance Dates. Business Associate further shall indemnify the Covered Entity and shall pay for the reasonable and actual costs associated and for any cost or damages, including attorney fees or fines, incurred by Covered Entity as a result of the breach by Business Associate, including but not limited to any identity theft related prevention or monitoring costs if the Covered Entity determines these services are appropriate as a result of the breach.

q. Business Associate agrees to comply with any and all privacy and security provisions not otherwise specifically addressed in the Contract made applicable to Business Associate by the ARRA on the applicable effective date as designated by ARRA and any subsequent regulations promulgated under ARRA and/or guidance thereto.

3.2 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. To inform the Business Associate of any changes in the form of notice of privacy practices (the "Notice") that the Covered Entity provides to individuals pursuant to 45 CFR §164.520, and provide, upon request, the Business Associate a copy of the Notice currently in use.

b. To inform the Business Associate of any changes in, or revocation of, the authorization provided to the Covered Entity by individuals pursuant to 45 CFR §164.508.

c. To inform the Business Associate of any opt-outs exercised by any individual from fundraising activities of the Covered Entity pursuant to 45 CFR §164.514(f).

d. To notify the Business Associate, in writing and in a timely manner, of any arrangements permitted or required of the Covered Entity under 45 CFR § part 160 and 164 that may impact in any manner the use and/or disclosure of Protected Health Information by the Business Associate under this Agreement, including, but not limited to, restrictions on use and/or disclosure of Protected

Health Information as provided for in 45 CFR §164.522 agreed to by the Covered Entity.

e. Within ten (10) business days of Covered Entity's knowledge, the Covered Entity agrees to notify the Covered Entity of any breach of unsecure PHI, as that term is defined in the ARRA and any subsequent regulations and/or guidance from the Secretary of DHHS, caused by Business Associate or any Business Associate agent or subcontractor performing under the Contract.

ADDITIONAL RESPONSIBILITIES OF THE PARTIES WITH RESPECT TO PROTECTED HEALTH INFORMATION

3.3 Responsibilities of the Business Associate with Respect to Handling of Designated Record Set. In the event that Business Associate maintains Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity, in a Designated Record Set, the Business Associate hereby agrees to do the following:

a. At the request of, and in the reasonable time and manner designated by the Covered Entity, provide access to the Protected Health Information to the Covered Entity or the individual to whom such Protected Health Information relates or his or her authorized representative in order for the Covered Entity to meet a request by such individual under 45 CFR §164.524.

b. At the request of, and in the reasonable time and manner designated by the Covered Entity, make any amendment(s) to the Protected Health Information that the Covered Entity directs pursuant to 45 CFR §164.526.

3.4 Additional Responsibilities of the Covered Entity. The Covered Entity hereby agrees to do the following:

a. Notify the Business Associate, in writing, of any Protected Health Information that Covered Entity seeks to make available to an individual pursuant to 45 CFR §164.524 and the time, manner, and form in which the Business Associate shall provide such access, if Business Associate maintains Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity, in a Designated Record Set.

b. Notify the Business Associate, in writing, of any amendment(s) to the Protected Health Information in the possession of the Business Associate that the Business Associate shall make and inform the Business Associate of the time, form, and manner in which such amendment(s) shall be made.

4. REPRESENTATIONS AND WARRANTIES

4.1 Mutual Representations and Warranties of the Parties. Each Party represents and warrants to the other party that it is duly organized, validly existing, and in good standing under the laws of the jurisdiction in which it is organized or licensed, it has the full power to enter into this Agreement and to perform its obligations hereunder, and that the performance by it of its obligations under this Agreement have been duly authorized by all necessary corporate or other actions and will not violate any provision of any license, corporate charter or bylaws.

5. TERM AND TERMINATION

5.1 Term. This Agreement shall become effective on the Effective Date and shall continue in effect until all obligations of the Parties have been met, unless terminated as provided in this Section 4. In addition, certain provisions and requirements of this Agreement shall survive its expiration or other termination in accordance with Section 6.3 herein.

5.2 Termination by the Covered Entity. As provided for under 45 C.F.R. §164.504(e)(2)(iii), the Covered Entity may immediately terminate this Agreement and any related agreements if the Covered Entity makes the determination that the Business Associate has breached a material term of this Agreement. Alternatively, the Covered Entity may choose to: (i) provide the Business Associate with thirty (30) days written notice of the existence of an alleged material breach; and (ii) afford the Business Associate an opportunity to cure said alleged material breach upon mutually agreeable terms. Nonetheless, in the event that mutually agreeable terms cannot be achieved within thirty (30) days, Business Associate must cure said breach to the satisfaction of the Covered Entity within thirty (30) days. Failure to cure in the manner set forth in this paragraph is grounds for the immediate termination of this Agreement.

5.3 Termination by Business Associate. If the Business Associate makes the determination that a material condition of performance has changed under the Contract or this Agreement, or that the Covered Entity has breached a material term of this Agreement, Business Associate may provide thirty (30) days notice of its intention to terminate this Agreement. Business Associate agrees, however, to cooperate with Covered Entity to find a mutually satisfactory resolution to the matter prior to terminating and further agrees that, notwithstanding this provision, it shall only terminate this Agreement in accordance with the Contract.

5.4 Automatic Termination. This Agreement will automatically terminate without any further action of the Parties upon the termination or expiration of the Contract.

5.5 Effect of Termination. Upon the event of termination pursuant to this Section 4, Business Associate agrees to return or destroy all Protected Health Information of the Covered Entity, as defined herein, pursuant to 45 C.F.R. §164.504(e)(2)(I), if it is feasible to do so. Prior to doing so, the Business Associate further agrees to recover any Protected Health Information in the possession of its subcontractors or

agents. If the Business Associate determines that it is not feasible to return or destroy said Protected Health Information, the Business Associate will notify the Covered Entity in writing. Upon mutual agreement of the Parties that the return or destruction is not feasible, Business Associate further agrees to extend any and all protections, limitations and restrictions contained in this Agreement to the Business Associate's use and/or disclosure of any Protected Health Information retained after the termination of this Agreement, and to limit any further uses and/or disclosures to the purposes that make the return or destruction of the Protected Health Information infeasible. If it is infeasible for the Business Associate to obtain, from a subcontractor or agent any Protected Health Information in the possession of the subcontractor or agent, the Business Associate must provide a written explanation to the Covered Entity and require the subcontractors and agents to agree to extend any and all protections, limitations and restrictions contained in this Agreement to the subcontractors' and/or agents' use and/or disclosure of any Protected Health Information retained after the termination of this Agreement, and to limit any further uses and/or disclosures to the purposes that make the return or destruction of the Protected Health Information infeasible.

6. MISCELLANEOUS

6.1 Covered Entity. For purposes of this Agreement, Covered Entity shall include all entities covered by the notice of privacy practices (or privacy notice) and who are parties to this Agreement.

6.2 Business Associate. For purposes of this Agreement, Business Associate shall include the named Business Associate herein. However, in the event that the Business Associate is otherwise a hybrid entity under the Privacy Regulation, that entity may appropriately designate a health care component of the entity, pursuant to 45 C.F.R. §164.504(a), as the Business Associate for purposes of this Agreement.

6.3 Survival. The respective rights and obligations of Business Associate and Covered Entity under the provisions of Sections 4.5, and Section 2.1 solely with respect to Protected Health Information Business Associate retains in accordance with Sections 2.1 and 4.5 because it is not feasible to return or destroy such Protected Health Information, shall survive termination of this Agreement.

6.4 Amendments; Waiver. This Agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events.

6.5 No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the

Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

6.6 Notices. Any notices to be given hereunder to a Party shall be made via U.S. Mail or express courier to such Party's address given below, and/or (other than for the delivery of fees) via facsimile to the facsimile telephone numbers listed below.

If to Business Associate, to:

_____
_____
_____
_____
Attention: _____
Phone: _____
Fax: _____

With a copy (which shall not constitute notice) to:

_____
_____
_____
_____
Attention: _____
Phone: _____
Fax: _____

If to Covered Entity, to:

Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621
_____
Attention: Commissioner
Phone: 502-564-4321
Fax: 502-564-0509

With a copy (which shall not constitute notice) to:

Office of Legal Services
Cabinet for Health and Family Services
275 East Main Street, 5W-B
Frankfort, Kentucky 40621
Attention: Privacy Officer
Phone: (502) 564-7905
Fax: (502) 564-7573

With a copy (which shall not constitute notice) to:

Office of Administrative & Technology Services
Cabinet for Health and Family Services
275 East Main Street, 4W-E
Frankfort, Kentucky 40621
Attention: Security Officer
Phone: (502) 564-6478
Fax: (502) 564-0203

Each Party named above may change its address and that of its representative for notice by the giving of notice thereof in the manner hereinabove provided.

6.7 Counterparts; Facsimiles. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original. Facsimile copies hereof shall be deemed to be originals.

6.8 Disputes. If any controversy, dispute or claim arises between the Parties with respect to this Agreement, the Parties shall make good faith efforts to resolve such matters informally.

7. DEFINITIONS

7.1 Designated Record Set. Designated Record Set shall have the meaning set out in its definition at 45 CFR §164.501, as such provision is currently drafted and as it is subsequently updated, amended, or revised.

7.2 Health Care Operations. Health Care Operations shall have the meaning set out in its definition at 45 CFR §164.501, as such provision is currently drafted and as it is subsequently updated, amended, or revised.

7.3 Privacy Officer. Privacy Officer shall mean the privacy official referred to in 45 CFR §164.530(a)(1) as such provision is currently drafted and as it is subsequently updated, amended, or revised.

7.4 Protected Health Information. Protected Health Information ("PHI") shall have the meaning as set out in its definition at 45 CFR §164.501, as such provision is currently drafted and as it is subsequently updated, amended, or revised.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf effective as of this _____ day of _____ _____ 20___.

COVERED ENTITY

By: _____

Neville Wise_____
Printed Name

Department for Medicaid Services, Acting Commissioner
Printed Title

_____
Date

BUSINESS ASSOCIATE

By: _____

_____
Printed Name

_____
Printed Title

_____
Date

Appendix Q

Annual Contract Monitoring Tools

Site Visit	___
Desk Review	___

Department for Medicaid Services

Administrative Monitoring Tool—FY 20XX

Contract Name: _____ **Contract Number:** _____

Monitoring Date(s): _____ **Monitor:** _____

Person(s) Interviewed: _____

Monitoring Items	Yes	No	N/A	Documentation
1. Corrective Action Plans resultant from the most recent Department for Medicaid Services (DMS) contract monitoring have been implemented by the Contractor.				
2. Notices, employment, advertisements, information pamphlets, research reports, and similar public notices prepared and released by the Contractor, pursuant to this contract, include a statement identifying the appropriate source of funds for the project or service, including but not limited to, identifying whether the funding is in whole or in part from federal, Cabinet for Health and Family Services (CHFS), or other state funds.				
3. Travel expenses are being paid by DMS.				
4. If Contractor is a non-Federal entity and expends $500,000 or more in a year in Federal awards, a single or program-specific audit has been				

conducted.				
5. For any and all subcontractors, the Contractor:				
A. Maintains a contract with the subcontractor;				
B. Specifies in the contract that all requirements of the contract between the Contractor and DMS are applicable and binding on the subcontractor; and,				
C. Monitors the subcontractor for programmatic and fiscal compliance.				
6. The Contractor maintains a property control ledger/log that lists all property and/or furniture provided (whether leased or purchased) by CHFS with funds from this contract.				
7. The Contractor maintains liability insurance for directors and officers, workers' compensation insurance, and employer liability insurance.				
8. The Contractor maintains a file of confidentiality agreements for all employees who have access to confidential information provided by CHFS.				

Comments/Observations

Managed Care

Contract Name: _____ **Contract Number: _____**

Contract Monitor: _____ **Monitoring Date(s): _____**

Monitoring Items	Yes	No	N/A	Documentation
1. Contractor provides medical services under a pre-paid capitated risk method for Medicaid eligible recipients.				
Organization				
2. Contractor has an office located within eighty (80) miles of Frankfort, KY that provides, at a minimum, the following staff functions:				
A. Executive Director for the KY account;				
B. Member Services for Grievances and Appeals; and,				
C. Provider Services for Provider Relations and Enrollment.				
3. Contractor ensures at least the following:				
A. At least one teaching hospital;				
B. Regional representation of all provider types on the Council's Board;				
C. A network of providers that includes:				
(1) Hospitals;				
(2) Home health;				
(3) Dentists;				
(4) Vision;				
(5) Hospice;				
(6) Pharmacy;				
(7) Prevention;				
(8) Primary care; and,				
(9) Maternity care providers.				
D. A provider network representing the complete array of provider types including:				
(1) Primary care providers;				

(2) Primary care centers;				
(3) Federally qualified health centers and rural health clinics;				
(4) Local health departments; and,				
(5) Ky Commission for Children with Special Health Care Needs.				
E. Licensed or contain an entity that is licensed as a health maintenance organization or provider-sponsored integrated health delivery program in the Commonwealth.				
Administration/Staffing				
4. Contractor provides staff for the following (functions may be combined or split among departments, people or subcontractors):				
A. Executive Management that provides oversight of the entire operation;				
B. Corporate Compliance Officer who ensures financial and programmatic accountability, transparency and integrity;				
C. Medical Director who is:				
(1) A KY-licensed physician;				
(2) Involved in all major clinical programs; and,				
(3) Involved in Quality Improvement components.				
D. Dental Director who is:				
(1) A dentist licensed by a Dental Board of Licensure in any state; and,				
(2) Actively involved in all major dental programs.				
E. Finance Officer and function, or designee to:				
(1) Oversee the budget and accounting systems implemented by the Contractor; and,				
(2) An internal auditor who				

ensures compliance with adopted standards and reviews expenditures for reasonableness and necessity.				
F. Member Services Director and function to coordinate communication with members and act as member advocates;				
G. Provider Services Director and function to coordinate all communications with Contractor's providers and subcontractors;				
H. Quality Improvement Director who is responsible for the operation of the QAPI Program or any subcontractors;				
I. Guardianship Liaison who serves as the Contractor's primary liaison for meeting the needs of members who are adult guardianship clients;				
J. Case Management Coordinator who is responsible for coordination and oversight of case management services and continuity of care for the Contractor's members;				
K. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Coordinator who coordinates and arranges for the provision of EPSDT services and EPSDT special services for members;				
L. Foster Care/Subsidized Adoption Liaison who serves as the Contractor's primary liaison for meeting the needs of members who are children in foster care and subsidized adoptive children;				
M. Management Information System Director and function who oversees, manages and				

maintains the Contractor's management information system (MIS);				
N. Behavioral Health Director who is a behavioral health practitioner and actively involved in all program or initiatives relating to behavioral health, and coordinates efforts to provide behavioral health services by the Contractor or any behavioral health subcontractors;				
O. Compliance Director who:				
(1) Oversees the Contractor's compliance with laws and contract requirements of the Department for Medicaid Services (DMS);				
(2) Serves as the primary contact for and facilitate communications between Contractor leadership and DMS relating to contract compliance issues; and,				

Monitoring Items	Yes	No	N/A	Documentation
(3) Oversees Contractor implementation of and evaluate any actions required to correct deficiency or address noncompliance with contract requirements as identified by DMS.				
P. Pharmacy Coordinator who coordinates, manages and oversees the provision of pharmacy services to members;				
Q. Claims processing function to ensure the timely and accurate processing of original claims, corrected claims, re-submissions and overall adjudication of claims;				
R. Program Integrity Coordinator to coordinate, manage and oversee the Contractor's Program Integrity unit to reduce fraud and abuse of Medicaid Services; and,				
S. Liaison to the Department for Medicaid Services (DMS) for all issues that relate to the contract between DMS and the Contractor.				
5. Contractor submits to DMS, annually, a current organizational chart depicting all functions including mandatory ones, number of employees in each functional department, and key managers responsible for the functions.				
Management Information System (MIS) Requirements				
6. Contractor maintains a MIS that provides support for all aspects of a managed care operation to include the following subsystems:				
A. Recipient;				
B. Third Party Liability (TPL);				

C. Provider;				
D. Reference;				
E. Encounter/Claims Processing;				
F. Financial;				
G. Utilization Data/Quality Improvement; and,				
H. Surveillance Utilization Review.				
7. Contractor ensures 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; and,				
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.				
Quality Assessment/Performance Improvement (QAPI)				
8. Contractor provides to DMS by July 31 the QAPI program description document.				
9. Contractor provides DMS a copy every three (3) years of its current National Committee for Quality Assurance (NCQA) certificate of accreditation and the complete survey report.				
10. Contractor prepares and submits to DMS by July 31 a written report detailing the annual QAPI review and evaluation.				
11. The QAPI work plan sets new goals and objectives annually based of findings from:				
A. Quality improvement activities				

and studies;				
B. Survey results;				
C. Grievances and appeals;				
D. Performance measures; and,				
E. External quality review findings.				
12. Contractor monitors and evaluates the quality of clinical care on an ongoing basis.				
13. The following health care needs are studied and prioritized for performance improvement and/or development of practice guidelines:				
A. Acute or chronic conditions;				
B. High volume;				
C. High risk;				
D. Special needs populations; and,				
E. Preventive care.				
14. In relation to Health Care Effectiveness Data and Information Set (HEDIS), Contractor collects and reports to DMS, by August 31st, the Final Auditor's Report issued by the NCQA.				
15. Contractor conducts a minimum of two (2) performance improvement projects (PIPs) each year, including one relating to physical health and one relating to behavioral health.				
16. Contractor establishes and maintains an ongoing Quality and Member Access Advisory Committee (QMAC) composed of :				
A. Members;				
B. Individuals from consumer advocacy groups or the community who represent the interests of the member population; and,				
C. Public health representatives.				
17. Contractor has a Utilization Management (UM) program that				

reviews services for medical necessity, and monitors and evaluates on an ongoing basis the appropriateness of care and services.				
18. The UM program is evaluated annually, the evaluation reviewed and approved annually by the Medical Director or the QI Committee.				
Adverse Actions Related to Medical Necessity or Coverage Denials				
19. Contractor gives members written notice of any action within the timeframes for each type of action that explains:				
A. The action the Contractor has taken or intends to take;				
B. The reasons for the action;				
C. The member's right to appeal;				
D. The member's right to request a State hearing;				
E. Procedures for exercising member's rights to appeal or file a grievance;				
F. Circumstances under which expedited resolution is available and how to request it; and,				
G. The member'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 member may be required to pay the costs of these services.				
20. Contractor gives notice at least:				
A. Ten (10) days before the date of action when the action is a termination, suspension, or reduction of a previously authorized covered service; or, five (5) days if member fraud or abuse has been determined				
B. By the date of the action for the following:				

(1) In the death of a member;				
(2) A signed written member statement requesting service termination or giving information requiring termination or reduction of services;				
(3) The member's admission to an institution where he is ineligible for further services;				
(4) The member's address is unknown and mail directed to him has no forwarding address;				
(5) The member has been accepted for Medicaid services by another local jurisdiction;				
(6) The member'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 member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a member has not resided in the nursing facility for thirty (30) days.				
C. On the date of action when the action is a denial of payment.				
21. Contractor gives notice as expeditiously as the member's health condition requires and				

within State-established timeframes that do not exceed two (2) working days following receipt of the request for service (with an extension of up to fourteen [14] additional days if the member or provider requests an extension or the Contractor justifies a need for additional information and how the extension is in the member's interest).				
22. If the Contractor extends the timeframe, the member is given written notice of the reason for the decision to extend and is informed of the right to file a grievance if he/she disagrees with that decision.				
23. For cases in which a provider indicates or the Contractor determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the Contractor makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and no later than two (2) working days after receipt of the request for service.				
24. Contractor gives notice on the date the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations.				
Assessment of Member and Provider Satisfaction and Access				
25. Contractor conducts an annual survey of members' and providers' satisfaction with the quality of services provided and their degree of access to				

services.				
26. Contractor provides DMS a copy of the current Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tool as approved.				
27. Contractor submits to DMS a copy of all survey tools and results including:				
A. A description of the methodology to be used conducting the provider or other special surveys;				
B. The number and percentage of the providers or members to be surveyed;				
C. Response rates;				
D. A sample survey instrument; and,				
E. Findings and interventions conducted or planned.				
Member Services Functions				
28. Contractor's member services function includes:				
A. A call center which is staffed and available by telephone Monday through Friday 7 a.m. to 7 p.m. Eastern Standard Time;				
B. A centralized toll-free call-in system, available 24/7, seven days a week nationwide, staffed by physicians, physician assistants, licensed practical nurses, or registered nurses;				
C. Providing a report to DMS, by the 10th of each month, prior month performance related to the call-in systems;				
D. Make available foreign language interpreters free of charge;				
E. Ensuring that member materials are provided and printed in each language spoken by five percent (5%) or more of the members in each county;				

F. Ability to respond to special communication needs of the disabled, blind, deaf and aged;				
G. Providing ongoing training to staff and providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals;				
H. Requiring all service locations to 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;				
I. Ensuring that members are informed of their rights and responsibilities;				
J. Monitoring the selection and assignment process of Primary Care Providers (PCPs);				
K. Identifying, investigating, and resolving member grievances about health care services;				
L. Assisting members with filing formal appeals regarding plan determinations;				

Monitoring Items	Yes	No	N/A	Documentation
M. Providing each member with an identification card that identifies the member as a participant within the Contractor's Network, unless otherwise approved by the Department;				
N. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud or abuse;				
O. Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific providers or services;				
P. Within three (3) business days of enrollment notification of a new member, by a method that will not take more than five (5) days to reach the member, and whenever requested by member, guardian or authorized representative, provide a Member Handbook and information on how to access services (alternate notification methods are available for persons who have reading difficulties or visual impairments);				
Q. Explaining or answering any questions regarding the Member Handbook;				
R. Facilitating the selection of or explaining the process to select or change PCPs through telephone or face-to-face contact where appropriate.				

(1) Contractor notifies members within thirty (30) days prior to the effective date of voluntary termination or as soon as Contractor receives notice, if notified less than thirty (30) days prior to the effective date.				
(2) Contractor notifies members within fifteen (15) days prior to the effective date of involuntary termination if their PCP leaves the programs.				
S. Facilitating direct access to specialty physicians in the circumstances of:				
(1) Members with long-term, complex conditions;				
(2) Aged, blind, deaf, or disabled persons; and,				
(3) Individuals who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring.				
T. 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;				
U. Making referrals for relevant non-program provider services such as the Women, Infants and Children (WIC) supplemental nutrition program and Protection and Permanency;				
V. Facilitating direct access to:				
(1) Primary care vision services;				
(2) Primary dental and oral surgery services and evaluations by orthodontists and prosthodontists;				
(3) Women's health specialists;				

(4) Voluntary family planning;				
(5) Maternity care for members under age 18;				
(6) Childhood immunizations;				
(7) Sexually transmitted disease screening, evaluation and treatment;				
(8) Tuberculosis screening, evaluation and treatment; and,				
(9) Testing for HIV, HIV-related conditions and other communicable diseases.				
W. Facilitating access to behavioral health services and pharmaceutical services;				
X. Facilitating access to the services of public health departments, rural health clinics, Federally Qualified Health Centers, the Commission for Children with Special Health Care Needs and charitable care providers;				
Y. Assisting members in making appointments with providers and obtaining services;				
Z. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;				
AA. Handling, recording and tracking member grievances properly and timely and acting as an advocate to assure members receive adequate representation when seeking an expedited appeal;				
BB. Facilitating access to member health education programs; and,				
CC. Assisting members in completing the Health Risk Assessment (HRA) form upon any telephone contact, and referring members 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.				
Member Handbook				
29. Contractor publishes a Member Handbook and makes the handbook available to members upon enrollment, to be delivered within five (5) business days to the member.				
30. Contractor reviews the handbook at least annually and communicates any changes to all members in written form.				
31. Revision dates are added to the handbook.				
32. Contractor ensures the handbook is written at the sixth grade reading comprehension level.				
33. The handbook includes:				
A. Contractor's network of primary care providers, including a list of the name, telephone numbers, and service site addresses of the PCPs available for primary care providers in the network listing;				
B. The procedures for selecting an individual physician and scheduling an initial health appointment;				
C. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and, the member services telephone numbers and toll-free 24-hour medical call-in system;				
D. A list of all available covered services, an explanation of any service limitations or exclusions				

from coverage and a notice stating that the Contractor will be liable only for those services authorized by the Contractor;				
E. Member rights and responsibilities including reporting suspected fraud and abuse;				
F. Procedures for obtaining emergency care and non-emergency after hours care;				
G. Procedures for obtaining transportation for both emergency and non-emergency situations;				
H. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;				
I. Procedures for arranging EPSDT for persons under the age of 21 years;				
J. Procedures for obtaining access to Long Term Care Services;				
K. Procedures for notifying DCBS of family size changes, births, address changes, death notifications;				
L. A list of direct access services that may be accessed without the authorization of a PCP;				
M. Information about procedures for selecting a PCP or requesting a change of PCP and specialists; reasons for which a request may be denied; and, reasons a provider may request a change;				
N. Information about how to access care before a PCP is assigned or chosen;				
O. Information about how to obtain second opinions related to surgical procedures, complex and/or chronic conditions;				

P. Procedures for obtaining covered services from non-network providers;				
Q. Procedures for filing a grievance or appeal, including the title, address and telephone number of the person responsible for processing and resolving grievances and appeals;				
R. Information about CHFS independent ombudsman program for members;				
S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;				
T. Information on the availability of health education services;				
U. Information deemed mandatory by DMS; and,				
V. The availability of care coordination case management and disease management provided by the Contractor.				
Member Services--Member Education and Outreach				
34. Contractor makes educational and outreach efforts with:				
A. Schools;				
B. Homeless centers;				
C. Youth service centers;				
D. Family resource centers;				
E. Public Health departments;				
F. School-based health clinics;				
G. Chamber of commerce; and,				
H. Faith-based community.				
35. Contractor submits an annual outreach plan to DMS for review and approval.				
36. The annual outreach plan includes;				
A. Frequency of activities;				
B. The staff person responsible for the activities; and,				
C. How the activities will be documented and evaluated for				

effectiveness and need for change.				
Member Services—Outreach to Homeless Persons				
37. Contractor assesses the homeless population within the region by implementing and maintaining a customized outreach plan for homeless population.				
38. The plan includes:				
A. Utilizing existing community resources such as shelters and clinics; and,				
B. Face-to-face encounters.				
Member Services—Member Information Materials				
39. Contractor ensures that all written materials provided to members are:				
A. Geared toward persons who read at a 6th grade level;				
B. Published in at least a fourteen (14) point font size; and,				
C. Comply with the Americans with Disabilities Act of 1990.				
40. Contractor ensures that Braille and audio tapes are available for the partially blind and blind.				
41. Contractor ensures provisions to review written materials for the illiterate are available.				
42. Contractor ensures that telecommunication devices for the deaf are available.				
43. Contractor ensures that language translation is available if five percent (5%) of the population in any county has a native language other than English.				
Member Rights and Responsibilities				
44. Contractor has written policies and procedures designed to protect the rights of members that include:				
A. Respect, dignity, privacy, confidentiality 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. To ask questions and receive complete information relating to the member'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 receive a hearing from the Contractor and/or the Department;				
F. Timely access to care that does not have any communication or physical access barriers;				
G. To prepare advance medical directives;				
H. To have access to medical records;				
I. Timely referral and access to medically indicated specialty care; and,				
J. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.				
Member Selection of Primary Care Provider Members Without SSI				
45. Contractor ensures a member without SSI is offered an opportunity to:				
A. Choose a new PCP who is affiliated with the Contractor's network; or,				
B. Stay with their current PCP as long as such PCP is affiliated with the Contractor's network.				
Monitoring Items	**Yes**	**No**	**N/A**	**Documentation**
46. Contractor sends members				

written explanations of the PCP selection process within ten (10) business days of receiving enrollment notification from DMS.				
47. The written communication includes:				
A. Timeframe for selection of a PCP;				
B. Explanation of the process for assignment of a PCP if the member does not select a PCP; and,				
C. Information on where to call for assistance with the selection process.				
48. Contractor ensures that members are allowed to select, from all available, but not less than two (2) PCPs in the Contractor's network.				
49. Contractor assigns the member to a PCP:				
A. Who has historically provided services to the member, meets the PCP criteria and participates in the Contractor's network;				
B. If there is no such PCP who has historically provided services, the Contractor assigns the member to a PCP, who participates in the Contractor's network and is within thirty (30) miles or thirty (30) minutes from the member's residence or place of employment in an urban area or within forty-five (45) miles or forty-five (45) minutes from the member's residence or place of employment in a rural area.				
50. Assigning of PCPs is based on:				
A. The need of children and adolescents to be followed by pediatric or adolescent specialists;				
B. Any special medical needs,				

including pregnancy;				
C. Any language needs made known to the Contractor; and,				
D. Area of residence and access to transportation.				
Members Who Have SSI and Non-Dual Eligibles				
51. Contractor sends members information regarding the requirement to select a PCP or one will be assigned to them according to the following:				
A. Upon enrollment, member will receive a letter requesting them to select a PCP. After one month, if the member has not selected a PCP, the Contractor sends a 2nd letter requesting the member to select a PCP within thirty (30) days or one will be chosen for the member.				
B. At the end of the third thirty (30) day period, if the member has not selected a PCP, the Contractor may select a PCP for the member and sends a card identifying the PCP selected for the member and informing the member specifically that the member can contact the Contractor and make a PCP change.				
C. Except for members who were previously enrolled, the Contractor cannot auto-assign a PCP to a member with SSI within the first ninety (90) days from the date of the member's initial enrollment.				
Primary Care Provider Changes				
52. Contractor has written policies and procedures for allowing members to select or be assigned to a new PCP when:				
A. Such a change is mutually agreed to by the Contractor and Member;				

Monitoring Items	Yes	No	N/A	Documentation
B. A PCP is terminated from coverage; or,				
C. A PCP change is as part of the resolution to an appeal.				
53. Contractor allows members to select another PCP within ten (10) days of the approved change.				
54. Contractor allows the member to change the PCP ninety (90) days after the initial assignment and once a year regardless of reason.				
Grievances and Appeals				
55. Contractor has a grievance system that includes a grievance process, an appeal process, and access for members to the State's hearing system.				
56. Contractor ensures a grievance documentation process that includes:				
A. Member name and identification number;				
B. Member's telephone number, when available;				
C. Nature of grievance;				
D. Date of grievance;				
E. Member's PCP or provider;				
F. Member's county of residence;				
G. Resolution;				
H. Date of resolution;				
I. Corrective action taken or required; and,				
J. Person recording grievance.				
57. Contractor has policies and procedures for the receipt, handling and disposition of grievances that:				
A. Are approved by the Contractor's governing bodies or board of directors;				
B. Are approved in writing by DMS prior to implementation;				
C. Include a process for evaluating patterns of grievances for				

impact on formulation of policy and procedures, access and utilization;				
D. Establish procedures for maintenance of records of grievances separate from medical case records and in a manner which protects the confidentiality of members who file a grievance or appeal;				
E. Inform members orally and/or in writing, about the Contractor's and State's grievance and appeal process, and by making information available at the Contractor's offices and service locations, and by distributing information to members upon enrollment and to subcontractors at time of contract;				
F. Provide assistance to member in filing grievances or appeals if requested or needed;				
G. Include assurance that there will be no discrimination against a member solely on the basis of the member filing a grievance or appeal; and,				
H. Include notification to members regarding how to access the Cabinet's ombudsman's office regarding grievance, appeals and state hearings.				
58. Contractor provides oral or written notice of the grievance resolution that includes:				
A. The results of the resolution process;				
B. The date it was completed; and,				
C. Any written response is provided within ninety (90) days following the initial filing of the grievance.				
Monitoring Items	**Yes**	**No**	**N/A**	**Documentation**
59. Contractor ensures written				

policies and procedures for responding to and resolving appeals by members.				
60. Contractor establishes written policies and procedures for the receipt, handling and disposition of appeals that includes:				
A. All appeals are submitted in writing within thirty (30) days of the aggrieved occurrence, either by the member or member's authorized representative, or a provider acting on behalf of a member with the member's written consent;				
B. The Contractor responds in writing within three (3) business days to the member filing the appeal, and includes the name and phone number of the staff to contact regarding the appeal;				
C. The Contractor provided an explanation regarding the continuation of services pending resolution of an appeal, if applicable;				
D. The Contractor continues to provide benefits for the member's services if:				
(1) The appeal is filed on or before the later of the following:				
a. Within ten (10) days of the Contractor mailing the notice; and,				
b. The intended effective date of the Contractor's proposed action.				
(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;				
(3) The services were ordered by an authorized provider;				

(4) The authorized period has not expired;				
(5) The member requests extension of benefits;				
(6) If the Contractor continues or reinstates the member's services while an appeal is pending, the services continue until one of the following occurs:				
a. The member withdraws the appeal;				
b. The member does not request a state hearing within ten (10) days from the date when the Contractor mails notices of an adverse decision;				
c. A state hearing decision adverse to the member is made; or,				
d. The authorization expires or authorization service limits are met.				
E. Contractor includes provisions for notifying members of the right to appeal the Contractor's disposition of an appeal to the state hearing process, including expedited time frames;				
F. Expedited appeals relating to matters which could place the member at risk or which could seriously jeopardize the member's health or well being are resolved with three (3) business days;				
G. Contractor allows the member and/or the member's authorized representative opportunity before and during the appeals process, to examine the member's appeals case file, including medical records and any other documents;				
Monitoring Items	**Yes**	**No**	**N/A**	**Documentation**

H. Contractor includes, as parties to the appeals:				
(1) The member and his or her authorized representative; or,				
(2) The legal representative of a deceased member's estate.				
61. Contractor provides written notice of the appeal resolution that includes:				
A. The results of the resolution process;				
B. The date it was completed;				
C. For appeals not resolved in favor of the member:				
(1) The right to request a state hearing and how to do so;				
(2) The right to request continuation of benefits, if applicable, while the state hearing is pending and how to make the request; and,				
(3) If the Contractor action is upheld in a state hearing, the member may be liable for the cost of any continued benefits.				
D. The written response is provided within thirty (30) days of the initial filing of the appeal.				
Enrollment				
62. Contractor sends a confirmation letter to the member, within three (3) business days after receipt of notification of new member enrollment, that includes:				
A. The effective date of enrollment;				
B. Site and PCP contact information;				
C. How to obtain referrals;				
D. The role of the Care Coordinator and Contractor;				
E. The benefits of preventive health care;				
F. Member identification card;				

G. Copy of the Member Handbook; and,				
H. List of covered services.				
Provider Services				
63. Contractor maintains a provider services function that includes:				
A. Enrolling, credentialing and recredentialing and performance review of providers;				
B. Assisting providers with member 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 a member of Contractor's network;				
F. Handling, recording and tracking provider grievances and appeals;				
G. Developing, distributing and maintaining a provider manual;				
H. Developing, conducting, and assuring provider orientation/training;				
I. Explaining the extent of Medicaid benefit coverage to providers including EPSDT preventive health screening services and EPSDT Special Services;				

Monitoring Items	Yes	No	N/A	Documentation
J. Communicating Medicaid policies and procedures, including state and federal mandates and new policies and procedures;				
K. Assisting providers in coordination of care for child and adult members with complex and/or chronic conditions;				
L. Encouraging and coordinating the enrollment of primary care providers in the Department for Public Health and DMS Services for Vaccines for Children Program;				
M. Coordinating workshops relating to the Contractor's policies and procedures; and,				
N. Providing technical support to providers who experience unique problems with certain members in their provision of services.				
64. Contractor ensures that providers services is staffed, at a minimum, Monday through Friday 8 A.M through 6 P.M. Eastern Standard Time.				
65. Contractor operates a provider call center.				
Provider Credentialing and Recredentialing				
66. Contractor documents the procedure for credentialing and recredentialing of providers that includes:				
A. Defining the scope of providers covered;				
B. The criteria and the primary source verification of information used to meet the criteria;				
C. The process used to make decisions; and,				

D. The extent of delegated credentialing and recredentialing arrangements.				
67. Contractor has a process for receiving input from participating providers regarding credentialing and recredentialing.				
68. Contractor has written policies and procedures of the process for verifying that specific providers are licensed and have current policies of malpractice insurance.				
69. Contractor maintains a file for each provider containing a copy of the provider's current license issued by the Commonwealth.				
70. Contractor ensures the process for verification of provider credentials and insurance includes:				
A. Written policies and procedures that include the Contractor's initial process for credentialing, as well as its recredentialing process that occurs, 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.				
71. Verification of provider's credentials includes:				
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/Bureau of Narcotics and Dangerous Drugs (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 of the State or County professional association; and,				
N. Most recent information available from the National Practitioner Data Bank.				
72. Before a practitioner is credentialed, the Contractor receives information from the following organizations and includes 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.				
73. Contractor has evidence that before making a recredentialing decision, information about sanctions or limitations on practitioner has been verified 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 or privileges or any disciplinary action; and,				
(4) Current malpractice insurance.				
74. Contractor generates a Credentialing Process Coversheet per provider that is submitted electronically to DMS' fiscal agent.				
75. Contractor establishes ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles.				
Primary Care Providers				
76. Contractor monitors primary care provider actions to ensure compliance with the Contractor's and DMS' policies that include:				
A. Maintaining continuity of the member's health care;				
B. Making referrals for specialty care and other medically necessary services, both in and out of plan, if such services are not available within the				

Contractor's network;				
C. Maintaining a current medical record for the member, including documentation of all PCP and specialty care services;				
D. Discussing advance medical directives with all members 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 DMS's specification; and,				
G. Arranging and referring members when clinically appropriate to behavioral health providers.				
77. Contractor ensures the following after-hours phone arrangements are implemented by PCPs in Contractor's network:				
A. 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;				
B. Office phone is answered after hours by a recording directing the member 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,				
Monitoring Items	**Yes**	**No**	**N/A**	**Documentation**

C. Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.				
Provider Manual				
78. Contractor prepares and issues a provider manual to all existing network providers.				
79. Contractor issues to newly contracted providers copies of the provider manual within five (5) working days from inclusion of the provider into the network.				
80. Contractor ensures the provider manual is the source of information to providers regarding:				
A. Covered services;				
B. Provider credentialing and recredentialing;				
C. Member grievances and appeals policies and procedures;				
D. Reporting fraud and abuse;				
E. Prior authorization procedures;				
F. Medicaid laws and regulations;				
G. Telephone access;				
H. The QAPI program; and,				
I. Standards for preventive health services.				
Provider Orientation and Education				
81. Contractor conducts initial orientation for all providers within thirty (30) days after the Contractor places a newly contracted provider on an active status.				
82. Contractor ensures that provider education includes:				
A. Contractor coverage requirements for Medicaid services;				
B. Policies or procedures and any modifications to existing				

services;				
C. Reporting fraud and abuse;				
D. Medicaid populations/eligibility;				
E. Standards for preventive health services;				
F. Special needs of members in general that affect access to and delivery of services;				
G. Advance medical directives;				
H. EPSDT services;				
I. Claims submission and payment requirements;				
J. Special health/care management programs that members may enroll in;				
K. Cultural sensitivity;				
L. Responding to needs of members with mental, developmental and physical disabilities;				
M. Reporting of communicable disease;				
N. The Contractors QAPI program;				
O. Medical records review; and,				
P. Rights and responsibilities of both members and providers.				
Medical Records				
83. Contractor ensures that member medical records are maintained either hard copy or electronically and include:				
A. Medical charts;				
B. Prescription files;				
C. Hospital records;				
D. Provider specialist reports;				
E. Consultant and other health care professionals' findings;				
F. Appointment records; and,				
G. Other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services.				
84. Contractor ensures medical records are signed by the provider of service.				

85. Contractor ensures the medical chart organization and documentation include:				
A. Member/patient identification information on each page;				
B. Personal/biographical data, including:				
(1) Date of birth;				
(2) Age;				
(3) Gender;				
(4) Marital status;				
(5) Race or ethnicity;				
(6) Mailing address;				
(7) Home and work addresses and telephone numbers;				
(8) Employer;				
(9) School;				
(10) Name and telephone numbers (if no phone, contact name and number) of emergency contacts;				
(11) Consent forms;				
(12) Identify language spoken; and,				
(13) Guardianship information.				
C. Date of data entry and date of encounter;				
D. Provider identification by name;				
E. Allergies, adverse reactions and no known allergies are 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);				
G. Identification of current problems;				
H. The consultation, laboratory, and radiology reports filed in the medical record contain the ordering provider's initials or other documentation indicating review;				

I. Documentation of immunizations;				
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 Dept. for Public Health;				
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.				
86. Contractor ensures members' medical records 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;				
D. Medication history, medications prescriber, including the strength, amount, directions for use and refills;				
E. Therapies and other prescribed				

regimen; and,				
F. Follow-up plans including consultation and referrals and directions, including time to return.				
Provider Grievances and Appeals				
87. Contractor implements a process to ensure that all appeals from providers are reviewed and the following details recorded in a written record and logged:				
A. Date;				
B. Nature of appeal;				
C. Identification of the individual filing the appeal;				
D. Identification of the individual recording the appeal;				
E. Disposition of the appeal;				
F. Corrective action required; and,				
G. Date resolved.				
88. Contractor ensures that every grievance received is documented in the MIS and contains the following:				
A. Provider name and identification number;				
B. Provider telephone number, when available;				
C. Nature of grievance;				
D. Date of grievance;				
E. Provider's county;				
F. Resolution;				
G. Date of resolution;				
H. Corrective action taken or required; and,				
I. Person recording the grievance.				
Release for Ethical Reasons				
89. Contractor ensures, in situations where a provider declines to perform a service because of ethical reasons, that members are 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 case appropriate to the member's medical condition.				
Network Providers to Be Enrolled				
90. Contractor enrolls the following into its network:				
A. At least one (1) Federally Qualified Health Center (FQHC) if there is a FQHC appropriately licensed to provide services in the region or service area;				
B. Physicians;				
C. Advanced practice registered nurses;				
D. Physician assistants;				
E. Birthing centers;				
F. Dentists;				
G. Primary care centers:				
H. Home health agencies;				
I. Rural health clinics;				
J. Opticians;				
K. Optometrists;				
L. Audiologists;				
M. Hearing aid vendors;				
N. Pharmacies;				
O. Durable medical equipment suppliers;				
P. Podiatrists;				
Q. Renal dialysis clinics;				
R. Ambulatory surgical centers;				
S. Family planning providers;				
T. Emergency medical transportation provider;				
U. Non-emergency medical transportation providers;				
V. Other laboratory and x-ray providers;				
W. Individuals and clinics providing EPSDT services;				
X. Chiropractors;				
Y. Community mental health centers;				
Z. Psychiatric residential treatment facilities;				
AA. Hospitals (including acute care,				

critical access, rehabilitation, and psychiatric hospitals);				
BB. Local health departments; and,				
CC. Providers of EPSDT Special services.				
91. Contractor has written policies and procedures regarding the selection and retention of Contractor's network.				
92. Contractor provides written notice to providers not accepted into the network along with the reasons for the non-acceptance.				
Termination of Network Providers or Subcontractors				
93. Contractor notifies DMS of suspension, termination and exclusion taken against a provider within three (3) business days via email.				
94. Contractor notifies DMS of voluntary terminations within five (5) business days via email.				
95. Contractor provides written notice within fifteen (15) days to a member whose PCP has been involuntary disenrolled and within thirty (30) days of a PCP who has voluntarily terminated participation in the Contractor's network.				
Provider Program Capacity Demonstration				
96. Contractor ensures that emergency medical services are made available to members twenty-four (24) hours a day, seven (7) days a week.				
97. Contractor ensures that urgent care services by any provider in the Contractor's program are made available within 48 hours of request.				
98. Contractor provides the following:				
A. PCP delivery sites that:				
(1) Are no more than forty-five (45) minutes or forty-five (45)				

miles from member residence;				
(2) Have no more than member to PCP ratio of 1500:1;				
(3) Have appointment and waiting times not to exceed thirty (30) days from date of a member's request for routine and preventive services and forty-eight (48) hours for urgent care.				
B. Have specialty care in which referral appointments to specialists do not exceed thirty (30) days for routine care or forty-eight (48) hours for urgent care;				
C. Have immediate treatment for emergency care at a health facility that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's network;				
D. Have hospital care for which transport time does not exceed thirty (30) minutes, except in non-urban areas where access time does not exceed sixty (60) minutes;				
E. Have general dental services for which transport time does not exceed one (1) hour (appointment and waiting times do not exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care);				
F. Have general vision, laboratory and radiology services for which transport time does not exceed one (1) hour (appointment and waiting times do not exceed thirty (30) days for regular appointments and forty-eight (48) hours for urgent				

care);				
G. Have pharmacy services with travel time not exceeding one (1) hour or the delivery site is no further than fifty (50) miles from the member's residence.				
Program Mapping				
99. Contractor submits maps and charts that include geographic details including highways, major streets and boundaries.				
100. Maps include the location of all categories of providers or provider sites as follows:				
A. Primary Care Providers (designated by "P");				
B. Primary Care Centers, non-FQHC and RHC (designated by "C");				
C. Dentists (designated by "D");				
D. Other Specialty Providers (designated by "S");				
E. Non-Physician Providers, including:				
(1) Nurse practitioners (designated by "N");				
(2) Nurse mid-wives (designated by "M"); and,				
(3) Physician assistants (designated by "A");				
F. Hospitals (designated by "H");				
G. After hours Urgent Care Centers (designated by "U");				
H. Local Health Departments (designated by "L");				
I. Federally Qualified Health Centers/Rural Health Clinics (designated by "F" or "R" respectively);				
J. Pharmacies (designated by "X");				
K. Family Planning Clinics (designated by "Z");				
L. Significant traditional providers (designated by "*");				
M. Maternity Care Physicians				

(designated by "o"; and,				
N. Vision Providers (designated by "V").				
Reporting Requirements				
101. Contractor monitors and documents in a quarterly report to DMS the number of eligible individuals that are assigned a PCP.				
102. Contractor submits to DMS on a quarterly basis the total number of member grievances and appeals and their disposition.				
103. The member grievances and appeals report includes:				
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				
104. Contractor monitors and evaluates in quarterly reports provider grievances and appeals regarding:				
A. The number of grievances and appeals;				
B. Type of grievances and appeals; and,				
C. Outcomes of provider grievances and appeals.				
105. Contractor provides all provider terminations in the monthly Provider Termination Report.				
106. Contractor submits to DMS on a quarterly basis a report summarizing changes in the Contractor's network.				
107. Contractor submits a quarterly report on EPSDT services.				
108. Contractor submits an annual				

report on EPSDT services.				
109. Contractor submits a quarterly report on the number of new member assessments; number of assessments completed, number of assessments not completed after reasonable efforts, and the number of refusals.				
110. Contractor submits a report of foster care cases thirty (30) days after the end of each month.				
111. Contractor submits thirty (30) days after the end of each quarter a report detailing the number of service plan reviews conducted for guardianship, foster and adoption assistance members outcome decisions, such as referral to case management, and rationale for decisions.				
112. Contractor provides to DMS a status report of the QAPI program and work plan on a quarterly basis thirty (30) days after the end of the quarter.				
Record System Requirements				
113. Contractor ensures the maintenance of detailed records relating to the operation of the Contractor, including:				
A. The administrative costs and expenses incurred pursuant to this contract;				
B. Member enrollment status;				
C. Provision of covered services;				
D. All relevant medical information relating to individual members for the purpose of audit, evaluation or investigation by DMS, the Office of Inspector General, the Attorney General and other authorized federal or state personnel;				
E. Quality improvement and				

utilization;				
F. All financial records;				
G. Performance reports indicating compliance with contract requirements;				
H. Fraud and abuse; and,				
I. Managerial reports.				
Reporting Requirements and Standards				
114. Contractor ensures that submitted reports meet these standards:				
A. Contractor verifies the accuracy for data and other information on reports submitted;				
B. Reports or other required data is received on or before scheduled due dates;				
C. Reports or other required data conforms to DMS' defined standards; and,				
D. All required information is fully disclosed in a manner that is responsive and without material omission.				
Ownership and Financial Disclosure				
115. Contractor provides disclosures of the following:				
A. 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. 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 subsection 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 Contactor 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,				

Monitoring Items	Yes	No	N/A	Documentation
G. The Contractor shall be required to notify DMS immediately when any change in ownership is anticipated. The Contractor shall submit a detailed work plan to DMS and to the Department of Insurance 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.				
116. Contractor provides disclosures to DMS:				
A. At the time of each annual audit;				
B. At the time of each Medicaid survey;				
C. Prior to entry into a new contract with DMS;				
D. Upon any change in operations which affects the most recent disclosure report; or,				
E. Within thirty-five (35) days following the date of each written request for such information.				

Comments/Observations