APPENDICES

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Appendix A - Service Area - Region 3

MCO Region 3 (includes the following 16 counties)

Breckinridge
Bullitt
Carroll
Grayson
Hardin
Henry
Jefferson
Larue
Marion
Meade
Nelson
Oldham
Shelby
Spencer
Trimble
Washington

Appendix B - Approved Capitation Payment Rates

Contract Term – January 1, 2013 THROUGH June 30, 2014

Region 3 Price Per Member Per Month Bid
(18 Month Bid)

	Region 3 PMPM January 2013 through June 2014
Families and Children	
Infant (age under 1)	719.42
Child (age 1 through 5)	141.76
Child (age 6 through 12)	184.37
Child (age 13 through 18) - Female	323.63
Child (age 13 through 18) - Male	249.05
Adult (age 19 through 24) - Female	710.47
Adult (age 19 through 24) - Male	235.83
Adult (age 25 through 39) - Female	740.84
Adult (age 25 through 39) - Male	406.01
Adult (age 40 or older) - Female	690.94
Adult (age 40 or older) - Male	603.20
SSI Adults without Medicare	
Adult (age 19 through 24) - Female	804.10
Adult (age 19 through 24) - Male	583.54
Adult (age 25 through 44) - Female	1,145.19
Adult (age 25 through 44) - Male	954.57
Adult (age 45 or older) - Female	1,492.04
Adult (age 45 or older) - Male	1,502.27
Waiver Option	
Dual Eligible	
All Ages - Female	170.12
All Ages - Male	154.77
SSI Children	
Infant (age under 1)	10,238.72
Child (age 1 through 5)	1,020.49
Child (age 6 through 18)	881.35
Foster Care	
Infant (age under 1)	3,846.71
Child (age 1 through 5)	340.77
Child (age 6 through 12)	782.69
Child (age 13 or older) - Female	1,183.93
Child (age 13 or older) - Male	923.98

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 III diagnosis and procedure updates
4. ADA (dental) codes

B. Processing Requirements

The Reference Processing function must include the following capabilities:

1. Maintain current and historical reference data, assuring that updates do not overlay or otherwise make historical information inaccessible.
2. Maintain a Procedure data set which is keyed to the five-character HCPCS code for medical-surgical and other professional services, ADA dental codes; a two-character field for HCPCS pricing modifiers; and the Department's specific codes for other medical services; in addition, the procedure data set will contain, at a minimum, the following elements for each procedure:
    - Thirty-six (36) months of date-specific pricing segments, including a pricing action code, effective beginning and end dates, and allowed amounts for each segment.
    - Thirty-six (36) months of status code segments with effective beginning and end dates for each segment.
    - Multiple modifiers and the percentage of the allowed price applicable to each modifier.
    - Indication of TPL actions, such as Cost Avoidance, Benefit Recovery or Pay, by procedure code.
    - Other information such as accident-related indicators for possible TPL, federal cost-sharing indicators, Medicare coverage and allowed amounts.
3. Maintain a diagnosis data set utilizing the three (3), four (4), and five (5) character for ICD-9-CM and 7 digits for ICD-10 and DSM III coding system, which supports relationship editing between diagnosis code and claim information including but not limited to:
    - Valid age
    - Valid sex
    - Family planning indicator
    - Prior authorization requirements
    - EPSDT indicator
    - Trauma diagnosis and accident cause codes
    - Description of the diagnosis
    - Permitted primary and secondary diagnosis code usage
4. Maintain descriptions of diagnoses.
5. Maintain flexibility in the diagnosis file to accommodate expanded diagnosis codes with the implementation of ICD-10 by October 1, 2013.
6. Maintain a drug data set of the eleven (11) digit National Drug Code (NDC), including package size, which can accommodate updates from a drug pricing service and the CMS Drug Rebate file updates; the Drug data set must contain, at a minimum:
    - Unlimited date-specific pricing segments that include all prices and pricing action codes needed to adjudicate drug claims.
    - Indicator for multiple dispensing fees

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

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

C. On-line Inquiry Screens

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

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

Provide inquiry screens that display:

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

D. Interfaces

The Reference Data Maintenance function must interface with:

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

4. NDC Codes.

I. Financial Subsystem

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

A. Inputs

The Financial Processing function must accept the following inputs:

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

B. Processing Requirements

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

C. Payment Processing

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

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

D. Adjustment Processing

The MIS adjustment processing function must have the capabilities to:

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

the adjustment so that the adjustment can be easily identified.

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

E. Other Financial Processing

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

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

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

C. Reports

Reports from the financial processing function are described in Appendix L

and Contractor Reporting Requirements Section of Contract.

II. Utilization/Quality Improvement

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

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

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

A. Inputs

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

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

B. Processing Requirements

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

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

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

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

III. Claims Control and Entry

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

IV. Edit/Audit Processing

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

V. Claims Pricing

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

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

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

A. Inputs

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

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

B. Processing Requirements

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

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

VI. Claims Operations Management

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

A. Inputs

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

B. Processing Requirements

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

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

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

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

C. Reports

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

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

Additional detail 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 initial.

DATA QUALITY STANDARDS FOR EVALUATION OF SUBMITTED ENCOUNTER DATA FIELDS Based on CMS Encounter Validation Protocol		
Data Element	**Expectation**	**Validity Criteria**
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=Speciatity, 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
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. v. Masten Childers, 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 and Reporting Deliverables

Document Name	MCO Reports Description
Date Created	September 4, 2011
Last Revised	August 28, 2012
Owner	Medicaid Managed Care Oversight Branch

Report #	Report Name	Status
1	NAIC Annual Financial Statement	Active
2	Audit/Internal Control	Active
3	NAIC Quarterly Financial Statement	Active
4	Executive Summary	Active
5	Enrollment Changes by Quarter	Inactive
6	Member Requested Change in PCP Assignment	Inactive
6	Member Requested Change in PCP Assignment (Annual)	Inactive
7	PCP Requested Change in Member Assignment	Inactive
7	PCP Requested Change in Member Assignment (Annual)	Inactive
8	MCO Initiated Change in PCP Assignment	Inactive
8	MCO Initiated Change in PCP Assignment (Annual)	Inactive
9	PCPs with Panel Changes Greater than 50 or 10%	Inactive
9	PCPs with Panel Changes Greater than 50 or 10% (Annual)	Inactive
10	Narrative for MCO Report #s 6-8	Inactive
11	Call Center	Active
12	Provider Network File Layout	Active
12A	Geo Access Network Reports and Maps	Active
13	Access and Delivery Network Narrative	Active
14	Denial of MCO Participation (Quarterly)	Inactive
15	Subcontractor Monitoring	Active
16	Summary of Quality Improvement Actives	Active
17	Quality Assessment and Performance Improvement Work Plan	Active
18	Monitoring Indicators, Benchmarks and Outcomes	Active
19	Performance Improvement Projects	Active
20	Utilization of Subpopulations and Individuals with Special Healthcare Needs	Active
21	MCO Committee Activity	Active
22	Satisfaction Survey(s)	Active
23	Evidence Based Guidelines for Practitioners	Active
24	Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death	Active
25	Overview of Activities	Inactive
26	Credentialing and Re-credentialing Activities During the Quarter	Inactive
27	Grievance Activity	Active
28	Appeal Activity	Active

29	Grievances and Appeals Narrative	Active
30	Quarterly Budget Issues	Active
31	Potential or Anticipated Fiscal Problems	Active
32	Enrollment Summary	Inactive
33	Utilization of Ambulatory Care by Age Breakdown	Inactive
34	Utilization of Emergency and Ambulatory Care Resulting in Hospital Admission	Inactive
35	Emergency Care by ICD-9 Diagnosis	Inactive
36	Home Health Utilization	Inactive
37	Utilization of Ambulatory Care by Provider Type and Category of Aid	Inactive
38	EPSDT Special Services	Active
39	Monthly Formulary Management	Active
40A	Top 50 Psych Drugs by Quantity Reimbursed	Active
40B	Top 50 Psych Drugs by Reimbursement	Active
41	Top 50 OTC Drugs by Reimbursement	Active
42A	Top 50 Prescribers by Reimbursement	Active
42B	Top 50 Prescribers of Controlled Drugs by Reimbursement	Active
42C	Top 50 BH Prescribers by Reimbursement	Active
43	Top 50 Controlled Drugs by Quantity Reimbursed	Active
44	Top 50 Drugs by MCO Reimbursement	Active
45a	Top 50 Drugs by Quantity	Active
45B	Top 50 Non PDL Drugs by Reimbursement	Active
46	Systems Development and Encounter Data	Inactive
47	Claims Processing Timeliness/Encounter Data Processing	Inactive
48	Organizational Changes	Active
49	Administrative Changes	Active
50	Innovations and Solutions	Inactive
51	Operational Changes	Active
52	Expenditures Related to MCO's Operations	Active
53	Prompt Payment	Active
54	COB Savings	Active
55	Medicare Cost Avoidance	Active
56	non-Medicare Cost Avoidance	Active
57	Potential Subrogation	Active
58	Original Claims Processed	Active
59	Prior Authorizations	Active
60	Original Claims Payment Activity	Active
61	Denied Claims Activity	Active
62	Suspended Claims Activity	Active
63	Claims Inventory	Active
64	Encounter Data	Inactive
65	Foster Care	Active
66	Guardianship	Active
67	Provider Credentialing Activity	Active
68	Provider Enrollment	Inactive
69	Termination from MCO Participation	Active
70	Denial of MCO Participation	Active
71	Provider Outstanding Accounts Receivables	Active
72	Medicaid Program Violation Letters and Collections	Active
73	Explanation of Member Benefits (EOMB)	Active
74A	Medicaid Program Lock-In Reports/Admits Savings	Active

	Summary Table	
74B	Medicaid Program Lock-In Reports/Rolling Annual Calendar Comparison	Active
74C	Medicaid Program Lock-In Reports/Member Initial Lock-In Effective Dates	Active
75	SUR Algorithms	Active
76	Provider Fraud Waste and Abuse	Active
77	Member Fraud Waste and Abuse	Active
78	Quarterly Benefits Payment	Active
79	Health Risk Assessments	Active
80	Provider Changes in Network	Active
81	Par and Non-Par Provider Participation	Active
82	Status of all Subcontractors	Inactive
83	Member TPL Resource Information	Inactive
84	Quality Assessment and Performance Improvement Project Description	Active
85	Quality Improvement Plan and Evaluation	Active
86	Annual Outreach Plan	Active
87	DMS Copied on Report to Management of any Changes in Member Services Function to Improve the Quality of Care Provided or Method of Delivery	Inactive
88	Absent Parent Canceled Court Order Information	Inactive
89	List of Members Participating with the Quality Member Access Advisory Committee	Inactive
90	Performance Improvement Projects Proposal	Active
91	Abortion Procedures	Active
92	Performance Improvement Projects Measurement	Active
93	EPSDT CMS – 416	Active
94	Member Surveys	Active
95	Provider Surveys	Active
96	Audited HEDIS Reports	Active
97	Behavioral Health Adults and Children	Active
98	Behavioral Health Pregnant and Postpartum	Active
99	Behavioral Health Intravenous Drug Users	Inactive
100	EPSDT for Behavioral Health Populations	Active
101	Behavioral Health Evidence Based Practices	Active
101A	Behavioral Health and Wellness	Active
102	Behavioral Health and Chronic Physical Health	Active
103	PRTF Residential Inpatient Readmission	Active
104	Behavioral Health Expenses PMPM	Active
105	Unduplicated Number of Adults and Children/Youth Received Services under 907 KAR 3:110	Inactive
106	Behavioral Health Pharmacy for all MCO Members – Adults and Children	Active
107	Behavioral Health Capacity	Active
108	Unduplicated Number of Adults and Children/Youth Received PRTF – Level I and Level II	Inactive
109	Unduplicated Number and Percentage of Adults and Children/Youth Readmitted to PRTF	Inactive
110	Behavioral Health Services by Procedure	Active
111	Unduplicated Number and Percentage of Adults with SMI	Inactive

112	Unduplicated Number and Percentage of Adults with SMI and Children/Youth with SED Received with Co-occurring Mental Health Abuse Disorders	Inactive
113	Unduplicated Number and Percentage of Children/Youth with SED Therapy or Family Functional Therapy	Inactive
114	Unduplicated Number and Percentage of Children/Youth with SED who were assessed for Trauma History	Inactive
115	Unduplicated Number of Adults and Children/Youth of their Caregivers Received Peer Support Service	Inactive
116	Unduplicated Number and Percentage of Pregnant and Post-partum women with Substance use Disorders Received First Treatment within 48 hours	Inactive
117	Unduplicated Number and Percentage of Children/Youth Discharged from PRTF	Inactive
118	Behavioral Health Outcome Summary	Active
119	Behavioral Health Statistics Improvement Project Adult Survey	Active
120	Behavioral Health Statistics Improvement Project Child Survey	Active
121	Unduplicated Number of Adults and Children/Youth with Behavioral Health Diagnosis' with PCP	Inactive
122	Unduplicated Number of Children/Youth with Behavioral Health Diagnoses Received Annual Wellness Check/Health Exam	Inactive
123	Unduplicated Number of Adults and Children/Youth General Behavioral Health Diagnosis and Chronic Physical Health Diagnosis	Inactive
124	Unduplicated Number of Adults and Children/Youth with Regular use of Tobacco Products	Inactive
125	Unduplicated Number of Adults and Children/Youth Screened for Substance Use Disorder in Physical Care Setting	Inactive
126	Federally Qualififed Health Centers	Active
127	Statement on Standards for Attestation Engagements (SSAE) No. 16	Active
200	Ineligible Assignment	Active
205	Assignment Inquiry	Active
210	Duplicate Member	Active
220	Newborn	Active
230	Capitation Payment Request	Active
240	Capitation Duplicate Payment	Active
250	Capitation Adjustment Requests	Active
260	MCO Claims Paid for Voided Members	Active

Exhibit #	Exhibit Name
Exhibit A	Billing Provider Type and Specialty Crosswalk
Exhibit B	Billing Provider Type Category Crosswalk
Exhibit C	Provider Enrollment Activity Reasons
Exhibit D	Category of Service Crosswalk

Exhibit E	EPSDT Category of Service Crosswalk
Exhibit F	Medicaid Eligibility Group Crosswalk
Exhibit G	BHDID General Population Definitions
Exhibit H	MH/SA Procedure Codes
Exhibit I	Mental Health Evidence Based Practices Definitions
Exhibit J	BHDID Psychotropic Medication Class Codes
Exhibit K	Behavioral Health and Chronic Physical Health

Note: A report will not be required to be submitted to the Department during the period the report has a status of 'Inactive'.

Report #:	1	Created:	09/10/2011
Name:	NAIC Annual Financial Statement	Last Revised:	09/24/2011
Group:	Finance and Medicaid Managed Care Oversight	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	January 1 through December 31		
Due Date:	Date Submitted to DOI		
Submit To:	Kentucky Department of Insurance Kentucky Department for Medicaid Services		

Description:

NAIC Financial Statement and Supplements are required by the Kentucky Department of Insurance (DOI). MCOs are required to comply with the DOI filing requirements. A copy of the NAIC Financial Statement and Supplements are required to be submitted to the Department for Medicaid Services (DMS) at the same time the reports are submitted to the DOI. Any revisions of the documents submitted to the DOI are also to be submitted to the DMS at the same time. Due date for the Annual Financial Statement and Supplements is March 1 as stated in the DOI NAIC Checklist for Health.

Report #:	2	Created:	09/10/2011
Name:	Audit/Internal Control	Last Revised:	09/24/2011
Group:	Finance and Medicaid Managed Care Oversight	Report Status:	Active
Frequency:	Annual or as Appropriate	Exhibits:	NA
Period:	As Required by DOI		
Due Date:	Date Submitted to DOI		
Submit To:	Kentucky Department of Insurance Kentucky Department for Medicaid Services		

Description:

MCOs are required to comply with the Kentucky Department of Insurance (DOI) requirements for Audit/Internal Control reporting as referenced in the DOI NAIC Checklist for Health. A copy of the Audit/Internal Control reports are required to be submitted to the Department for Medicaid Services (DMS) at the same time the reports are submitted to the DOI. Any revisions of the documents submitted to the DOI are also to be submitted to the DMS at the same time.

Report #:	3	Created:	09/10/2011
Name:	NAIC Quarterly Financial Statement	Last Revised:	09/24/2011
Group:	Finance and Medicaid Managed Care Oversight	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA

Period:	First day of the quarter through the last day of the quarter.		
Due Date:	Date Submitted to DOI		
Submit To:	Kentucky Department of Insurance Kentucky Department for Medicaid Services		

Description:

NAIC Quarterly Financial Statement and Supplements are required by the Kentucky Department of Insurance (DOI). MCOs are required to comply with the DOI filing requirements. A copy of the NAIC Quarterly Financial Statement and Supplements are required to be submitted to the Department for Medicaid Services (DMS) at the same time the reports are submitted to the DOI. Any revisions of the documents submitted to the DOI are also to be submitted to the DMS at the same time. Due dates for the Quarterly Financial Statement and Supplements are May 15, August 15 and November 15 as stated in the DOI NAIC Checklist for Health.

Report #:	4	Created:	12/12/2011
Name:	Executive Summary	Last Revised:	
Group:	Executive Summary	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

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

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 4: Executive Summary

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

I. Significant Operational Activities
- A. Overview of Success Stories and Positive Results
- B. Problems or Issues Identified
- C. Other Plan Activities

II. Summary of Reports
- A. Eligibility and Enrollment;
- B. Access/Delivery Network
- C. Quality Assurance/Performance Improvement (QAPI)

D. Grievance/Appeals
E. Budget Neutrality
F. Utilization
G. Systems
H. Other Plan Activities

III. Summary of Media/Press Releases

Media Source	Name	Date	Title-Subject	Highlight-Overview

Report #:	11	Created:	08/27/2011
Name:	Call Center	Last Revised:	09/01/2011
Group:	Member Services and Quality	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 10th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provides MCO reporting of call center performance in the areas of abandonment, blockage rate and average speed of answer. A total for all Splits/VDN and each individual Split/VDN is to be reported.

Sample Layout:

Member (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Behavioral Health (Main/Trunk)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Provider (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Medical Advice (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

<List Other by Name> (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
<List Other by Name>	The report is to include all Main/Trunk lines that the MCO or the MCO subcontractors maintain. Additional sections of the report are to be added as needed.

Row Label	Description
Number of Calls	Number of calls received including answered, abandoned and blocked.
Number of Calls Abandoned	Calls into the call centers that are terminated by the persons originating the call before answer by a staff person. (URAC standards measure this as the calls that disconnect after 30 seconds when a live individual would have answered the call. If there is a pre-recorded message or greeting for the caller, the 30-second measurement begins after the message/greeting has ended).
% Abandoned Calls	The percentage of calls into the call center that are terminated by the persons originating the call before answer by a staff person. (URAC standards measure this as the percentage of calls that disconnect after 30 seconds when a live individual would have

	answered the call. If there is a pre-recorded message or greeting for the caller, the 30-second measurement begins after the message/greeting has ended)
Average Speed to Answer (seconds)	The average delay in seconds that inbound telephone calls encounter waiting in the telephone queue of a call center before answer by a staff person (URAC measures the speed of answer starting at the point when a live individual would have answered the call. If there is a pre-recorded message or greeting for the caller, the time it takes to respond to the call – average speed of answer – begins after the message/greeting has ended).
Highest Maximum Delay (minutes)	The one call during the reporting period that had the greatest delay in speed to answer measured in minutes.
% Calls Answered on or before 4th Ring	The percentage of calls answered on or before the fourth ring.
% Calls Receiving Busy Signal	The percentage of incoming telephone calls 'blocked' or not completed because switching or transmission capacity is unavailable, as compared to the total number of calls encountered. Blocked calls usually occur during peak call volume periods and result in callers receiving a busy signal.
% Calls Answered within 30 Seconds	The percentage of calls answered within thirty seconds.
Average Length of Call (minutes)	The average length of all calls answered measured in minutes.

Column Label	Description
Total All Incoming Calls/VDN	Report a total for all incoming calls to the Main/Trunk line.
<name of split>	A separate column needs to be added to the report for each individual Split/VDN maintained for the Main/Trunk line.
mm/yyyy	The reporting period represented by a two character number for the month (mm) and a four character number for the year (yyyy). Example: January 2012 would be represented as 01/2012.

Report #:	12	Created:	02/06/2012
Name:	Provider Network File Layout	Last Revised:	
Group:	Access/Delivery Network	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCOs should provide MCO Provider Network File layouts as provided in Appendix G of the MCO Contract Appendices.

Sample Layout:

MCO's should produce monthly Network Provider files based on the layout requirements in Appendix G of the MCO Contract Appendices.

Report #:	12A	Created:	02/06/2012

Name:	Geo Access Network Reports and Maps	Last Revised:	
Group:	Access/Delivery Network	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	Ongoing		
Due Date:	July 31st		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO's should provide the GEO Access Network Reports and Maps on an annual basis or or upon request by the Department.

Sample Layout:

Title page, table of contents, accessibility standard comparison, accessibility standard detail, accessibility detail, accessibility summary, member map, provider listing, provider map, service area detail.

Maps shall include geographic detail including highways, major streets and the boundaries of the MCO's network. In addition to the maps and charts, the MCO shall provide an analysis of the capacity to serve all categories of Members. The analysis shall address the standards for access to care.
Maps shall include the location of all categories of Providers or provider sites as follows:

A. Primary Care Providers (designated by a "P");
B. Primary Care Centers, non FQHC and RHC (designated by a "C");
C. Dentists (designated by a "D");
D. Other Specialty Providers (designated by a "S");
E. Non-Physician Providers - including nurse practitioners, (designated by a "N") nurse mid-wives (designated by a "M") and physician assistants (designated by a "A");
F. Hospitals (designated by a "H");
G. After hours Urgent Care Centers (designated by a "U");
H. Local health departments (designated by a "L");
I. Federally Qualified Health Centers/Rural Health Clinics (designated by a "F" or "R" respectively);
J. Pharmacies (designated by a "X");
K. Family Planning Clinics (designated by an "Z");
L. Significant traditional Providers (designated by an "*");
M. Maternity Care Physicians (designated by a "º");
N. Vision Providers (designated by a "V"); and
O. Community Mental Health Centers (designated by a "M").

Report #:	13	Created:	02/06/2012
Name:	Access and Delivery Network Narrative	Last Revised:	
Group:	Access/Delivery Network	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		

Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCOs should provide specific information on Access Issues/Problems Identified on the nature of any access problems identified and any plans or remedial action taken.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 13: Access and Delivery Network Narrative

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

IV. Summary of Complaints - Access Issues
D. Provider
E. Member

V. Network Access Problems
I. Issue
J. Remedial Action Taken

Report #:	15	Created:	12/12/2011
Name:	Subcontractor Monitoring	Last Revised:	
Group:	Access Delivery Network	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

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 sample layout for each subcontractor/vendor.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 15: Subcontractor Monitoring

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

I. Subcontractor Name

A. Topic
B. Discussion
C. Action
D. Follow up from Previous Quarters Action

II. Subcontractor Name

A. Topic
B. Discussion
C. Action
D. Follow up from Previous Quarters Action

III. Subcontractor Name

A. Topic
B. Discussion
C. Action
D. Follow up from Previous Quarters Action

Report #:	16	Created:	12/12/2011
Name:	Summary of Quality Improvement Activities	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

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.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 16: Summary of Quality Improvement Activities

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

I. MCO completed the following activities during the quarter:

A. Improving Availability
B. Continuity
C. Quality of Services

Report #:	17	Created:	01/09/2012
Name:	Quality Assessment and Performance Improvement Work Plan	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

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

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 17: Quality Assessment and Performance Improvement Work Plan

MCO Name:	**DMS Use Only**
Report Date:	Received Date:
Report Period From:	Reviewed Date:
Report Period To:	Reviewer:

II. Quality Improvement

D. Improving Availability
E. Continuity
F. Quality of Services

Report #:	18	Created:	12/12/2011
Name:	Monitoring Indicators, Benchmarks and Outcomes	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

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

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

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 18: Monitoring Indicators, Benchmarks and Outcomes

MCO Name:	**DMS Use Only**
Report Date:	Received Date:
Report Period From:	Reviewed Date:
Report Period To:	Reviewer:

I. MCO completed the following activities during the quarter:

A. Monitoring
B. Benchmarks
C. Outcomes

Report #:	19	Created:	12/12/2011
Name:	Performance Improvement Projects	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Report on the progress and status of performance improvement projects.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 19: Performance Improvement Projects

MCO Name:	**DMS Use Only**
Report Date:	Received Date:
Report Period From:	Reviewed Date:
Report Period To:	Reviewer:

I. Following Activities/Initiatives occurred during the quarter:

A. Access to and Availability of Services
B. Depression
C. Emergency Department Use Management
D. Screenings for Breast Cancer, Cervical Cancer and Chlamydia

Report #:	20	Created:	12/12/2011
Name:	Utilization of Subpopulations and Individuals with Special Healthcare Needs	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Discuss any issues that arose during the report period that related to persons associated with sub-populations and individuals with special healthcare needs. Examples of sup-populations and individuals with special health care needs include members with chronic and disabling conditions, minorities, children enrolled with the Commission for Children with Special Health Care Needs, persons receiving SSI, persons with mental illness, the disabled, homeless, and any groups identified by the Contractor for targeted study. Discuss progress in the development of new or ongoing outreach and education to these special populations.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 16: Summary of Quality Improvement Activities

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

I. Following Outreach/Education to Special Populations (population examples):

A. Children with Special Healthcare Needs
B. Activities Related to the Homeless Population
C. Foster Care/Out of Home Placement
D. Guardianship
E. Smoking Cessation
F. COPD
G. Asthma
H. Diabetes

Report #:	21	Created:	01/13/2012
Name:	MCO Committee Activities	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provide a summary of the any MCO committee activities that met during the reporting period, including changes to

the committee structure, if any, and any decisions regarding quality and appropriateness of care. Provide copies of meeting minutes and reports of any special focus groups.

Kentucky Department for Medicaid Services
MCO Report # 21: MCO Committee Activities

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

I. Quality and Member Access Committee

A. Committee Structure
B. Committee Decisions (quality and appropriateness of care)
C. Provide list of members on committee

II. Committee Name

A. Committee Structure
B. Committee Decisions (quality and appropriateness of care)
C. Provide list of members on committee

III. Committee Name

A. Committee Structure
B. Committee Decisions (quality and appropriateness of care)
C. Provide list of members on committee

Report #:	22	Created:	01/09/2012
Name:	Satisfaction Survey(s)	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Describe results of any satisfaction survey that was conducted by the MCO during the report period, if applicable. (Note: surveys CAHPS are conducted each year, so this section will be completed one quarter for the providers and one for the members) at a minimum.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 22: Satisfaction Survey(s)

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

I. Satisfaction Survey

A. Population Surveyed
B. Results

Report #:	23	Created:	01/13/2012
Name:	Evidence Based Guidelines for Practitioners	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

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.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 23: Evidence Based Guidelines for Practitioners

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

II. Approved the renewal of the following Clinical Practice Guidelines (CPG):

C. Chronic Kidney Disease (CKD)
D. Chronic Obstructive Pulmonary Disease for Adults
E. Results

Report #:	24	Created:	01/13/2012
Name:	Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provide an overview of activities related to EPSDT, Pregnant Women, Maternal and Infant Death programs and trends noted in prenatal visit appropriateness, birth outcomes, including death, and program interventions. 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.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 24: Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death

MCO Name:	**DMS Use Only**
Report Date:	Received Date:
Report Period From:	Reviewed Date:
Report Period To:	Reviewer:

I. Pregnant Women
- A. Prenatal Visit
- B. Results
- C. Program Interventions

II. Maternal and Infant Death Programs
- A. Birth Outcomes
- B. Death Outcomes
- C. Program Interventions

III. EPSDT
- A. Activities of EPSDT staff
- B. Outreach
- C. Education
- D. Case Management
- E. Screening Rates (data/graph)
- F. Participation Rates (data/graph)

Report #:	27	Created:	08/27/2011
Name:	Grievance Activity	Last Revised:	09/24/2011
Group:	Grievance and Appeals	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Report provides summarized activity for both Member and Provider Grievances during the reporting period. The MCO is to crosswalk their unique Member and Provider grievance categories to the Medicaid grievance categories listed on the report. The crosswalk is to be submitted to the Department for Medicaid services (DMS) prior to the initial submission of the report. The crosswalk is to be updated and submitted to the DMS when additions or deletions of MCO grievance categories occur. The new crosswalk is to highlight any changes made from the previous crosswalk. Submission of the updated crosswalk shall be prior to the initial submission of the report that includes the changes to the MCO's grievance categories. If the MCO does not maintain their own Member and

Provider grievance categories and configures their systems to match the Medicaid categories then a certification of that activity is to be provided in lieu of the crosswalk.

Sample Layout:

Member Grievance Category	Beginning Balance	Total Received	Total Resolved	Avg. Time Resolution	Ending Balance
After Hours Access					
Appointment Availability					
Authorization Appeal					
Benefits/Eligibility Issue					
All Other					

Provider Grievance Category	Beginning Balance	Total Received	Total Resolved	Avg. Time Resolution	Ending Balance
Appointment Not Timely					
Benefits Eligibility Issue					
Claims Denied-No Referral/Authorization					
All Other					

Reporting Criteria:

Terminology	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
NA	NA

Column Label	Description
Member	Member initiated grievances are to be reported under the Member group.
Provider	Provider initiated grievances are to be reported under the Provider Group
Grievance Category	Specific categories to be used by the MCO for reporting grievances. If a grievance includes more than one issue then report each issue in the appropriate Grievance Category.
Beginning Balance	Total number of outstanding grievances at the beginning of the first day of the reporting period.
Total Received	Total number of grievances received during the reporting period.
Total Resolved	Total number of grievances resolved during the reporting period.
Avg. Time Resolution	Average number of days for all grievances resolved during the reporting period.
Ending Balance	Total number of outstanding grievances at the end of the last day of the reporting period.

Report #:	28	Created:	08/27/2011

Name:	Appeal Activity	Last Revised:	10/12/2011
Group:	Member and Financial	Report Status:	Active
Frequency:	Quarterly	Exhibits:	A, B, D
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Report provides a summarized activity for both Member and Provider Appeals during the reporting period. Member appeals are based on Category of Service (COS) while Provider Appeals are based on Billing Provider Type/Category.

Two (2) Billing Provider Types are further broken down as follows:

1. Billing Provider Type 01 General Hospital
    a. Inpatient;
    b. Outpatient;
    c. Emergency Room; and
    d. Inpatient/Outpatient Other
2. Billing Provider Type 54 Pharmacy
    a. Pharmacy non-Behavioral Health Brand;
    b. Pharmacy non-Behavioral Health Generic;
    c. Pharmacy Behavioral Health Brand; and
    d. Pharmacy Behavioral Health Generic

An appeal submitted by a Provider on the Member's behalf is to be reported under Member Appeal Activity.

Sample Layout:

Member Appeal Activity																								
COS	Category of Service (COS) Description	Beginning Balance	Ending Balance	Received						Resolved														Appeals Extended by 14 Calendar Days
				Total	Expedited		Non Expedited			Total	Expedited % Resolved in 3 Working Days	Non Expedited % Resolved in 30 Calendar Days	Non Expedited Average Days for Resolution	Written Notice of Resolution within 30 Calendar Days	Expedited				Non Expedited				
					Oral	Written	Oral	Written	5 Working Days Written Notice Provided						Final Disposition			Moved to Non Expedited	Oral Abandoned	Final Disposition			
															Upheld	Overturned	Partially Overturned			Upheld	Overturned	Partially Overturned	
Medicaid Mandatory Services																								
02	Inpatient Hospital																							
12	Outpatient Hospital																							
32	EPSDT Related																							
	Subtotal: Mandatory Services	0	0	0	0	0	0	0	0	0			0	0	0	0	0	0	0	0	0	0	0

Medicaid Optional Services

03	Mental Hospital																						
04	Renal Dialysis Clinic																						
	Subtotal: Optional Services	0	0	0	0	0	0	0	0	0			0	0	0	0	0	0	0	0	0	0	0

Total: Mandatory and Optional	0	0	0	0	0	0	0	0	0			0	0	0	0	0	0	0	0	0	0	0

Provider Appeal Activity															
Provider Type/Category	Beginning Balance	Ending Balance	Received				Resolved								Appeals Extended by 14 Calendar Days
			Total	Oral	Written	5 Working Days Written Notice Provided	Total	% Resolved in 30 Calendar Days	Average Days for Resolution	Written Notice of Resolution within 30 Calendar Days	Oral Abandoned	Upheld	Overturned	Partially Overturned	
Inpatient															
Outpatient															
Unknown Type															
Total	0	0	0	0	0	0	0		0	0	0	0	0	0	0

Reporting Criteria:

Terminology	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
COS	Two character designation for a state specific category of service. Crosswalk may be found in Exhibit D.
Category of Service (COS) Description	A description for the 'COS'.
Medicaid Mandatory Services	State covered Medicaid services required by federal law.
Subtotal: Mandatory Services	Calculated field. Sum total of all services listed as mandatory services. For columns with % Resolved it is the % resolved for all mandatory services. For columns with Average Days it is the average days of resolution for all mandatory services.
Medicaid Optional Services	State covered Medicaid services in addition to the mandatory covered services the state has chosen to cover.
Subtotal: Optional Services	Calculated field. Sum total of all services listed as optional services. For columns with % Resolved it is the % resolved for all optional services. For columns with Average Days it is the average days of resolution for all optional services.

Total: Mandatory and Optional	Calculated field. Total of all mandatory and optional services. For columns with % Resolved it is the % resolved for all mandatory and optional services. For columns with Average Days it is the average days of resolution for all mandatory and optional services.
Provider Type/Category	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk. Crosswalk of Provider Type Categories for General Hospital and Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Total	Calculated field. Total of all Provider Type/Category listed in the report. For columns with % Resolved it is the % resolved for all Provider Type/Category listed in the report. For columns with Average Days it is the average days of resolution for all Provider Type/Category listed in the report.

Column Label	**Description**
Member: Beginning Balance	Total number of outstanding appeals at the beginning of the first day of the reporting period.
Member: Ending Balance	Total number of outstanding appeals at the end of the last day of the reporting period.
Member: Received: Total	Total number of appeals received during the reporting period.
Member: Received: Expedited	Total number of expedited appeals received within the reporting period broken down by Oral and Written.
Member: Received: Expedited: Oral	Total number of expedited oral appeals received within the reporting period.
Member: Received: Expedited: Written	Total number of expedited written appeals received within the reporting period.
Member: Received: Non Expedited	Total number of non expedited appeals received within the reporting period broken down by Oral and Written.
Member: Received: Non Expedited: Oral	Total number of non expedited oral appeals received within the reporting period.
Member: Received: Non Expedited: Written	Total number of non expedited written appeals received within the reporting period.
Member: Received: Non Expedited: 5 Working Days Written Notice Provided	Total number of written notices provided within five (5) working days for non-expedited appeals.
Member: Resolved: Total	Total number of appeals resolved during the reporting period.
Member: Resolved: Expedited % Resolved in 3 Working Days	Total percentage of expedited appeals resolved in three (3) or fewer working days.
Member: Resolved: Non Expedited % Resolved in 30 Calendar Days	Total percentage of non expedited appeals resolved in thirty (30) or fewer calendar days.
Member: Resolved: Non Expedited Average Days for Resolution	Average number of days to resolve all non expedited appeals excluding non expedited appeals extended by fourteen (14) calendar days.
Member: Resolved: Written Notice of Resolution within 30 Calendar Days	Total number of written notice of resolution that were provided within thirty (30) calendar days of receipt of a non expedited appeal.
Member: Resolved: Expedited	An appeal that is required to be resolved within three (3) calendar days).
Member: Resolved: Final Disposition	Result of the expedited or non expedited appeal process broken down by upheld, overturned and partially overturned.
Member: Resolved: Expedited: Final Disposition: Upheld	Total number of expedited appeals that were resolved during the reporting period and were upheld. Upheld means that the prior decision was confirmed and remains as is.
Member: Resolved: Expedited: Final disposition: Overturned	Total number of expedited appeals that were resolved during the reporting period and were overturned. Overturned means that the prior decision was not confirmed and was reversed.
Member: resolved: Expedited: Final	Total number of expedited appeals that were resolved during the reporting

disposition: Partially Overturned	period and were partially overturned. Partially overturned means that part of the prior decision was not confirmed and was reversed.
Member: Resolved: Expedited: Moved to Non Expedited	Number of expedited appeals that moved to a non expedited appeal process.
Member: Resolved: Non Expedited: Oral Abandoned	A non expedited appeal that was not followed up by a written appeal and no additional action was taken.
Member: Resolved: Non Expedited: Final Disposition: Upheld	Total number of non expedited appeals that were resolved during the reporting period and were upheld. Upheld means that the prior decision was confirmed and remains as is.
Member: Resolved: Non Expedited: Final Disposition: Overturned	Total number of non expedited appeals that were resolved during the reporting period and were overturned. Overturned means that the prior decision was not confirmed and was reversed.
Member: Resolved: Non Expedited: Final Disposition: Partially Overturned	Total number of non expedited appeals that were resolved during the reporting period and were partially overturned. Partially overturned means that part of the prior decision was not confirmed and was reversed.
Member: Appeals Extended by 14 Calendar Days	The total number of non expedited appeals that were extended by fourteen (14) calendar days beyond the initial thirty (30) calendar day period.
Provider: Beginning Balance	Total number of outstanding appeals at the beginning of the first day of the reporting period.
Provider: Ending Balance	Total number of outstanding appeals at the end of the last day of the reporting period.
Provider: Received: Total	Total number of appeals received during the reporting period.
Provider: Received: Oral	Total number of oral appeals received within the reporting period.
Provider: Received: Written	Total number of written appeals received within the reporting period.
Provider: Received: 5 Working Days Written Notice Provided	Total number of written notices provided within five (5) working days.
Provider: Resolved: Total	Total number of appeals resolved during the reporting period.
Provider: Resolved: % Resolved in 30 Calendar Days	Total percentage of appeals resolved in thirty (30) or fewer calendar days.
Provider: Resolved: Average Days for Resolution	Average number of days to resolve all appeals excluding appeals extended by fourteen (14) calendar days.
Provider: Resolved: Written Notice of Resolution within 30 Calendar Days	Total number of written notice of resolution that were provided within thirty (30) calendar days of receipt of a non expedited appeal.
Provider: Resolved: Oral Abandoned	An oral appeal that was not followed up by a written appeal and no additional action was taken.
Provider: Resolved: Upheld	Total number of appeals that were resolved during the reporting period and were upheld. Upheld means that the prior decision was confirmed and remains as is.
Provider: Resolved: Overturned	Total number of appeals that were resolved during the reporting period and were overturned. Overturned means that the prior decision was not confirmed and was reversed.
Provider: Resolved: Partially Overturned	Total number of appeals that were resolved during the reporting period and were partially overturned. Partially overturned means that part of the prior decision was not confirmed and was reversed.
Provider: Appeals Extended by 14 Calendar Days	The total number of appeals that were extended by fourteen (14) calendar days beyond the initial thirty (30) calendar day period.

Report #:	29	Created:	02/06/2012
Name:	Grievances and Appeals Narrative	Last Revised:	
Group:	Grievances and Appeals	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		

Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Discuss any trends or problem areas identified in the appeals and grievance and address opportunity for improvement.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report #29: Grievances and Appeals Narrative

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

VI. Member Grievances
- F. Trends
- G. Problems or Issues Identified
- H. Opportunity for Improvement

VII. Provider Grievances
- A. Trends
- B. Problems or Issues Identified
- C. Opportunity for Improvement

VIII. Member Appeals
- A. Trends
- B. Problems or Issues Identified
- C. Opportunity for Improvement

IX. Provider Appeals
- A. Trends
- B. Problems or Issues Identified
- C. Opportunity for Improvement

Report #:	30	Created:	10/08/2011
Name:	Quarterly Budget Issues	Last Revised:	10/09/2011
Group:	Finance and Medicaid Managed Care Oversight	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of quarter.		
Due Date:	Thirty (30) calendar days after quarter end.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Quarterly Budget Issues report provides an executive level summary of budgetary issues including trends and impacts to operations. The information is to be provided as outlined in the layout below. The following is to be reported in the event a particular section does not apply during the reporting period: NO INFORMATION TO REPORT FOR THE PERIOD FROM <first day of reporting period formatted as mm/dd/yyyy> TO <last day of

reporting period formatted as mm/dd/yyyy>.

Layout:

Kentucky Department for Medicaid Services
MCO Report # 30: Quarterly Budget Issues

MCO Name:	**DMS Use Only**
Report Date:	Received Date:
Report Period From:	Reviewed Date:
Report Period To:	Reviewer:

A. Revenue (*For each item briefly discuss revenues received during the quarter versus budget, changes in revenue from previous quarter, reason(s) for changes from previous quarter and projected impact to operations.*)

1. Premiums
   - i. Received
   - ii. Changes
   - iii. Reasons
   - iv. Impacts
2. Investment
   - i. Received
   - ii. Changes
   - iii. Reasons
   - iv. Impacts
3. Pharmacy Rebate
   - i. Received
   - ii. Changes
   - iii. Reasons
   - iv. Impacts
4. Other
   - i. Received
   - ii. Changes
   - iii. Reasons
   - iv. Impacts

B. Expenses (*For each item briefly discuss expenses during the quarter versus budget, changes in expenses from previous quarter, reason(s) for changes from previous quarter and projected impact to operations.*)

1. Medical (non-subcontracted)
   - i. Expenses
   - ii. Changes
   - iii. Reasons
   - iv. Impacts
2. Medical (subcontracted)
   - i. Expenses
   - ii. Changes
   - iii. Reasons
   - iv. Impacts
3. Administrative (non-subcontracted)
   - i. Expenses
   - ii. Changes
   - iii. Reasons
   - iv. Impacts
4. Administrative (sub-contracted)
   - i. Expenses

ii. Changes
iii. Reasons
iv. Impacts

5. Other
   i. Expenses
   ii. Changes
   iii. Reasons
   iv. Impacts

C. Per Member Per Month (PMPM) (*Briefly discuss on an aggregate PMPM basis the revenue and expenses recognized during the reporting period, changes from previous reporting period and changes from and impacts to budget.*)

1. Premiums
2. Medical Costs (include medical loss ratio)
3. Changes (previous quarter)
4. Changes (budget)
5. Impacts (budget)

Report #:	31	Created:	10/08/2011
Name:	Potential or Anticipated Fiscal Problems	Last Revised:	10/09/2011
Group:	Finance and Medicaid Managed Care Oversight	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of quarter.		
Due Date:	Thirty (30) calendar days after quarter end.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Potential or Anticipated Fiscal Problems report provides an executive level summary of fiscal issues impacting operations and includes corrective actions taken during the quarter or planned for future dates. The information is to be provided as outlined in the layout below. The following is to be reported in the event a particular section does not apply during the reporting period: NO INFORMATION TO REPORT FOR THE PERIOD FROM <first day of reporting period formatted as mm/dd/yyyy> TO <last day of reporting period formatted as mm/dd/yyyy>.

Layout:

Kentucky Department for Medicaid Services
MCO Report # 31: Potential or Anticipated Fiscal Problems

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

(*For each item briefly identify any existing, anticipated or potential fiscal problems or issues and the corrective actions taken or to be taken*)

A. Claims Payment

1. Fiscal Problem(s)
2. Other Issues
3. Corrective Action(s)

B. Subcontractor Payments
1. Fiscal Problem(s)
2. Other Issues
3. Corrective Action(s)

C. Department of Insurance Risk Based Capital Requirements
1. Fiscal Problem(s)
2. Other Issues
3. Corrective Action(s)

D. Financial Solvency
1. Fiscal Problem(s)
2. Other Issues
3. Corrective Action(s)

E. Other
1. Fiscal Problem(s)
2. Other Issues
3. Corrective Action(s)

Report #:	38	Created:	08/28/2012
Name:	ESPDT Special Services	Last Revised:	NA
Group:	Utliziation	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First Day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should provide EPSDT Special Services (Provider Type 45). Report will contain provider types (dentist, home heatlh, etc) and the following data elements:

- Procedure codes billed
- Number of unduplicated members utilizing each procedure code
- Ununduplicated number of providers billing the code
- Total dollars paid
- Any new codes that were added during the report month

Sample Layout:

To be defined.

Reporting Criteria:

To be defined.

Report #:	39	Created:	01/04/2012
Name:	Monthly Formulary Management Report	Last Revised:	02/07/2012
Group:	Pharmacy	Report Status:	Active

Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Monthly summary of pharmacy related utilization and costs by Medicaid members assigned to Managed Care Organizations broken down by region.

Sample Layout:

		NOV-11	DEC-11	JAN-12	% CHANGE PER MONTH	% CHANGE PER YEAR	AVERAGE PER MONTH	Y-T-D
STATISTICS	NEW RXS							
	REFILL RXS							
	TOTAL NON PDL RXS							
	% NON PDL RXS							
	PSYCH RXS							
	% PSYCH RXS							
	NON PDL PSYCH RXS							
	% NON PDL PSYCH RXS							
	# PSYCH UTILIZERS							
	% PSYCH UTILIZERS							
	% PSYCH UTILIZERS/RX UTILIZERS							
	# PSYCH RXS/MEMBER							
	# PSYCH RXS/PSYCH UTILIZER							
	# RXS/MEMBER LESS PSYCHS							
	% MEMBERS ON MEDS LESS PSYCHS							
	PSYCH COST/PSYCH UTILIZER							
	# PROVIDER PRESCRIBED OTCS							
	# CONTROLLED RXS							
	% BRAND							
	% GENERIC							

BEHAVIORAL HEALTH	% ATYP ANTIPSYCH UTILIZERS							
	% MEMBERS ON ATYP ANTIPSYCHS/RX UTILIZERS							
	# TYPICAL ANTIPSYCH UTILIZERS							
	% TYPICAL ANTIPSYCH UTILIZERS							
	# MEMBERS ON ATYP TO TYP							
	BH % BRAND							
	BH % GENERIC							
PERCENTAGES	% PDL COST/TOTAL COST							
	% NON PDL COST/TOTAL COST							
	% PSYCH COST/TOTAL COST							
	% PDL PSYCH COST/TOTAL COST							
	% NON PDL PSYCH COST/TOTAL COST							
	% ATYP ANTIPSYCH COST/TOTAL COST							
	% HIV COST/TOTAL COST							
	% HEP B COST/TOTAL COST							
	% HEP C COST/TOTAL COST							
SPECIALTY	HEP C RXS							
	# HEP C UTILIZERS							
	HEP C RX COST							
	HEP C COST/HEP C UTILIZER							
	HEP B RXS							
	# HEP B UTILIZERS							
	HEP B RX COST							
	HEP B COST/HEP B UTILIZER							
	HEP B COST/MEMBER							
	HIV RXS							
	# HIV UTILIZER							
	HIV RX COST							

	HIV COST/HIV UTILIZER							
COST	TOTAL COST							
	DRUG REIMBURSEMENT							
	DISPENSING FEES							
	TOTAL COST/MEMBER							
	COST/RX UTILIZER							
	PDL TOTAL COST							
	PDL COST/MEMBER							
	NON PDL TOTAL COST							
	NON PDL COST/MEMBER							
	PSYCH COST							
	PSYCH COST/MEMBER							
	PDL PSYCH COST							
	PDL PSYCH COST/MEMBER							
	NON PDL PSYCH COST							
	NON PDL PSYCH COST/MEMBER							
	ATYP ANTIPSY COST							
	ATYP ANTIPSY COST/MEMBER							
	ATYP ANTIPSYCH COST/ATYP ANTIPSY UTILIZER							
	PROVIDER PRESCRIBED OTC TOTAL COST							
	PROVIDER PRESCRIBED OTC COST/MEMBER							
	TOTAL INSULIN COST							
	PROVID3ER PRESCRIBED OTC COST LESS INSULIN							
	H2 BLOCKERS TOTAL COST							
	NSAIDS TOTAL COST							
	PPI TOTAL COST							
	VACCINE TOTAL COST							
AL REGI	# MEMBERS							

	% UTILIZERS							
	# RXS							
	AVG # RXS/MEMBER							
	AVG # RXS/UTILIZER							
	# PAs							
	% PAs DENIED							
	# CLAIMS							
	% CLAIMS DENIED							
	# PRESCRIBERS							
	# RXS/PRESCRIBER							
	# CONTROLS/ PRESCRIBER							
	# PHARMACIES							
	AVG COST/RX							
	SUBOXONE RXS							
	ADHD RXS							
	LOCK INS							
REGION 1	# MEMBERS							
	% UTILIZERS							
	# RXS							
	AVG # RXS/MEMBER							
	AVG # RXS/UTILIZER							
	# PAs							
	% PAs DENIED							
	# CLAIMS							
	% CLAIMS DENIED							
	# PRESCRIBERS							
	# RXS/PRESCRIBER							
	# CONTROLS/ PRESCRIBER							
	# PHARMACIES							
	AVG COST/RX							
	SUBOXONE RXS							
	ADHD RXS							
	LOCK INS							

Reporting Criteria:

Terminology	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Definition
NEW RXS	Number of new prescriptions
REFILL RXS	Number of refill prescriptions
TOTAL NON PDL RXS	Total number of prescriptions written for a drug not listed on the preferred drug list
% NON PDL RXS	Percentage of prescriptions written for a drug not listed on the preferred drug list
PSYCH RXS	Number of prescriptions written for a psychotropic drug
% PSYCH RXS	Percentage of prescriptions written for a drug not listed on the preferred drug list
NON PDL PSYCH RXS	Number of prescriptions written for a psychotropic drug not listed on the preferred drug list
% NON PDL PSYCH RXS	Percentage of prescriptions written for a psychotropic drug not listed on the preferred drug list
# PSYCH UTILIZERS	Number of Medicaid /MCO members for whom psychotropic drug prescriptions were filled
% PSYCH UTILIZERS	Percentage of Medicaid /MCO members for whom psychotropic drug prescriptions were filled
% PSYCH UTILIZERS/RX UTILIZERS	Percentage of Medicaid/MCO members for whom psychotropic drug prescriptions were filled as compared to total Medicaid/MCO members for whom any drug prescriptions were filled
# PSYCH RXS/MEMBER	Number of psychotropic prescriptions per Medicaid/MCO member
# PSYCH RXS/PSYCH UTILIZER	Number of psychotropic prescriptions per Medicaid/MCO member who fills prescriptions written for psychotropic medications
# RXS/MEMBER LESS PSYCHS	Number of prescriptions per Medicaid/MCO member not counting prescriptions for psychotropic medications
% MEMBERS ON MEDS LESS PSYCHS	Percentage of Medicaid/MCO members for whom drug prescriptions were filled not counting prescriptions for psychotropic medications
PSYCH	Psychotropic drug cost/Medicaid/MCO member for whom psychotropic medication were filled

COST/PSYCH UTILIZER	
# OTC RXS	Number of prescriptions filled for over the counter items
# CONTROLLED RXS	Number of prescriptions filled for controlled (scheduled) narcotics
% BRAND	Percentage of prescriptions filled with brand name drugs
% GENERIC	Percentage of prescriptions filled with a generic drug
ATYP ANTIPSYCH RXS	Number of prescriptions filled for a atypical antipsychotropic drug
NON PDL ATYP ANTI PSYCH RXS	Number of prescriptions filled for a atypical antipsychotropic drug not listed on the preferred drug list
# ATYP ANTIPSYCH UTILIZERS	Number of Medicaid/MCO members for whom drug prescriptions for atypical antipsychotics were filled
% ATYP ANTIPSYCH UTILIZERS	Percentage of Medicaid/MCO members for whom drug prescriptions were filled for atypical antipsychotics
% MEMBERS ON ATYP ANTIPSYCHS/RX UTILIZERS	Percentage of Medicaid/MCO members for whom drug prescriptions were filled for atypical antipsychotics as compared to total Medicaid/MCO members for whom any drug prescriptions were filled
# TYPICAL ANTIPSYCH UTILIZERS	Number of Medicaid/MCO members for whom drug prescriptions for typical antipsychotics were filled
% TYPICAL ANTIPSYCH UTILIZERS	Percentage of Medicaid/MCO members for whom drug prescriptions for typical antipsychotics were filled
BH % BRAND	Percentage of behavioral health prescriptions filled with a brand name drug
BH % GENERIC	Percentage of behavioral health prescriptions filled with a generic drug
% PDL COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs on the preferred drug list as compared with total drug cost
% NON PDL COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs on the non preferred drug list as compared with total drug cost
% PSYCH COST/TOTAL COST	Percentage of drug cost for prescriptions filled with psychotropic drugs as compared with total drug cost

% PDL PSYCH COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs on the preferred drug list as compared with total drug cost
% NON PDL PSYCH COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs not on the preferred drug list as compared with total drug cost
% ATYP ANTIPSYCH COST/TOTAL COST	Percentage of drug cost for prescriptions filled with atypical antipsychotrpic drugs as compared with total drug cost
% HIV COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs used to treat HIV as compared with total drug cost
% HEP B COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs used to treat Hep B as compared with total drug cost
% HEP C COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs used to treat Hep C as compared with total drug cost
HEP C RXS	Number of prescriptions filled with drugs used to treat Hep C
# HEP C UTILIZERS	Number of Medicaid/MCO members for whom prescriptions for drugs used to treat Hep C are filled
HEP C RX COST	Total cost for prescriptions filled with drugs used to treat Hep C
HEP C COST/HEP C UTILIZER	Cost for prescriptions filled with drugs used to treat Hep C per Medicaid/MCO member for whom prescriptions for drugs used to treat Hep C are filled
HEP B RXS	Number of prescriptions filled with drugs used to treat Hep B
# HEP B UTILIZERS	Number of Medicaid/MCO members for whom prescriptions for drugs used to treat Hep B are filled
HEP B RX COST	Total cost for prescriptions filled with drugs used to treat Hep B
HEP B COST/HEP B UTILIZER	Cost for prescriptions filled with drugs used to treat Hep B per Medicaid/MCO member for whom prescriptions for drugs used to treat Hep B are filled
HIV RXS	Number of prescriptions filled with drugs used to treat HIV
# HIV UTILIZER	Number of Medicaid/MCO members for whom prescriptions for drugs used to treat HIV are filled
HIV RX COST	Total cost for prescriptions filled with drugs with HIV indication

HIV COST/HIV UTILIZER	Cost for prescriptions filled with drugs with HIV indication per Medicaid/MCO member for whom prescriptions for drugs with HIV indication are filled
TOTAL COST	Total drug cost = Total Drug Reimbursement + Dispensing Fees
TOTAL DRUG REIMBURSEMENT	Total reimbursed for drugs dispensed to Medicaid members
DISPENSING FEES	Total dispensing fees to pharmacies
TOTAL COST/MEMBER	Total drug cost per Medicaid/MCO member
COST/RX UTILIZER	Total drug cost per Medicaid/MCO member for whom prescriptions for any drug are filled
PDL TOTAL COST	Total drug cost for prescriptions filled for drugs listed on the preferred drug list
PDL COST/MEMBER	Total drug cost for prescriptions filled for drugs listed on the preferred drug list per Medicaid/MCO member
NON PDL TOTAL COST	Total drug cost for prescriptions filled for drugs not listed on the preferred drug list
NON PDL COST/MEMBER	Total drug cost for prescriptions filled for drugs not listed on the preferred drug list per Medicaid/MCO member
PSYCH COST	Total drug cost for prescriptions filled with psychotropic drugs
PSYCH COST/MEMBER	Total drug cost for prescriptions filled with psychotropic drugs per Medicaid/MCO member
PDL PSYCH COST	Total drug cost for prescriptions filled with psychotropic drugs listed on the preferred drug list
PDL PSYCH COST/MEMBER	Total drug cost for prescriptions filled with psychotropic drugs listed on the preferred drug list per Medicaid/MCO member
NON PDL PSYCH COST	Total drug cost for prescriptions filled with psychotropic drugs not listed on the preferred drug list
NON PDL PSYCH COST/MEMBER	Total drug cost for prescriptions filled with psychotropic drugs not listed on the preferred drug list per Medicaid/MCO member
ATYP ANTIPSY COST	Total drug cost for prescriptions filled with atypical antipsychotic drugs
ATYP ANTIPSY COST/MEMBER	Total drug cost for prescriptions filled with atypical antipsychotic drugs per Medicaid/MCO member
ATYP ANTIPSYCH COST/ATYP ANTIPSY UTILIZER	Total drug cost for prescriptions filled with atypical antipsychotic drugs per Medicaid/MCO member for whom prescriptions for atypical antipsychotic drugs are filled

OTC TOTAL COST	Total cost for prescriptions filled for over the counter items
OTC COST/MEMBER	Total cost for prescriptions filled for over the counter items per Medicaid MCO member
TOTAL INSULIN COST	Total cost for prescriptions filled with insulin
OTC COST LESS INSULIN	Total cost for prescriptions filled for over the counter items minus total cost for prescriptions filled with insulin
H2 BLOCKERS TOTAL COST	Total cost for prescriptions filled with any drug listed in the histamine H2 acid reducers drug category
NSAIDS TOTAL COST	Total cost for prescriptions filled with any drug listed in the non-steroidal anti-inflammatory drug category
PPI TOTAL COST	Total cost for prescriptions filled with any drug listed in the proton pump inhibitor drug category
# MEMBERS	Number of Medicaid/MCO members
% UTILIZERS	Percentage of Medicaid/MCO members for whom prescriptions are filled
# RXS	Number of prescriptions filled for Medicaid/MCO members
AVG # RXS/MEMBER	Average number of prescriptions filled for each Medicaid/MCO member
AVG # RXS/UTILIZER	Average number of prescriptions filled for each Medicaid/MCO member for whom prescriptions are filled
# PAs	Number of prior authorizations for drug items requested
% PAs DENIED	Percentage of prior authorization requests denied as compared to total number of prior authorizations requested
# CLAIMS	Number of prescriptions claims
% CLAIMS DENIED	Percentage of prescription claims denied as compared to total number of paid claims
# PRESCRIBERS	Number of Medicaid/MCO providers who prescribed medications for Medicaid/MCO members for whom prescriptions were filled
# RXS/PRESCRIBER	Number of prescriptions filled for Medicaid/MCO members filled for any drug per provider who prescribed medications for Medicaid/MCO members for whom prescriptions were filled
# CONTROLS/ PRESCRIBER	Number of prescriptions filled for controlled (scheduled) narcotics per provider who prescribed medications for Medicaid/MCO members for whom prescriptions were filled
# PHARMACIES	Number of pharmacies where prescriptions were filled for Medicaid/MCO members

AVG COST/RX	Average cost of prescriptions filled for Medicaid/MCO members per prescription filled for Medicaid/MCO members
SUBOXONE RXS	Number of Suboxone prescriptions filled for Medicaid/MCO members
ADHD RXS	Number of prescriptions filled with any drug listed in the attention deficit hyperactivity disorder drug category
# LOCK IN MEMBERS	Number of Medicaid/MCO members placed in a Lock In program

Column Label	Description
Nov 11	Information for the entire month
Dec 11	Information for the entire month
Jan 12	Information for the entire month
% Change per Month	The percentage change realized from one rolling month to the next
% Change per Year	The percentage change realized from one rolling year to the next
Average per Month	The average of the requested information per month
Y-T-D	Total of requested information through the last reporting period

Report #:	40A	Created:	02/10/2012
Name:	Top 50 Psych Drugs by Quantity Reimbursed	Last Revised:	08/28/2012
Group:	Pharmacy	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should provide a report the top 50 psychotropic drugs ranked by quantity reimbursed for psychotropic drugs dispensed.

Sample Layout:

	Drug Name/Strength/Dosage Form	Cost/Month
1		
2		
3		
4		
5		

Reporting Criteria:

Row Label	Description
Columns 1-50	Ranking from 1 = most quantity to 50 = least quantity

Column Label	Description
Drug Name/Strength/Dosage Form	Name of Drug, Strength of Drug, and Dosage Form of Drug
Cost/Month	The total cost (reimbursement) for the ranked drug for specified time period

Report #:	40B	Created:	02/10/2012
Name:	Top 50 Psych Drugs by Reimbursement	Last Revised:	08/28/2012
Group:	Pharmacy	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provide a report the top 50 psychotropic drugs ranked by amount of reimbursement paid by MCOs for psychotropic drugs dispensed.

Sample Layout:

	Drug Name/Strength/Dosage Form	Cost/Month
1		
2		
3		
4		
5		

Reporting Criteria:

Row Label	Description
Columns 1-50	Ranking from 1 = most quantity to 50 = least quantity

Column Label	Description
Drug Name/Strength/Dosage Form	Name of Drug, Strength of Drug, and Dosage Form of Drug
Cost/Month	The total cost (reimbursement) for the ranked drug for specified time period

Report #:	41	Created:	02/10/2012
Name:	Top 50 OTC Drugs by Reimbursement	Last Revised:	08/28/2012
Group:	Pharmacy	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should provide a report the top 50 OTC drugs ranked by reimbursement for OTC drugs dispensed.

Sample Layout:

	Drug Name/Strength/Dosage Form	Cost/Month
1		
2		
3		
4		
5		

Reporting Criteria:

Row Label	Description
Columns 1-50	Ranking from 1 = most quantity to 50 = least quantity

Column Label	Description
Drug Name/Strength/Dosage Form	Name of Drug, Strength of Drug, and Dosage Form of Drug
Cost/Month	The total cost (reimbursement) for the ranked drug for specified time period

Report #:	42A	Created:	02/10/2012
Name:	Top 50 Prescribers by Reimbursement	Last Revised:	02/20/2012
Group:	Pharmacy	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provide a report the top 50 prescribers ranked by amount of reimbursement paid by MCOs for drugs dispensed.

Sample Layout:

	Prescriber Name	NPI Number
1		
2		
3		
4		
5		

Reporting Criteria:

Row Label	Description
Columns 1-50	Ranking from 1 = most quantity to 50 = least quantity

Column Label	Description
Prescriber name	The name of the prescriber who ranks to the corresponding number
NPI Number	The NPI number which corresponds to the prescriber in the second column

Report #:	42B	Created:	02/10/2012
Name:	Top 50 Prescribers of Controlled Drugs by Reimbursement	Last Revised:	02/20/2012
Group:	Pharmacy	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should provide a report the top 50 prescribers of controlled drugs ranked by amount of reimbursement paid by MCOs for controlled drugs dispensed.

Sample Layout:

	Prescriber Name	NPI Number
1		
2		
3		
4		
5		

Reporting Criteria:

Row Label	Description
Columns 1-50	Ranking from 1 = most quantity to 50 = least quantity

Column Label	Description
Prescriber name	The name of the prescriber who ranks to the corresponding number
NPI Number	The NPI number which corresponds to the prescriber in the second column

Report #:	42C	Created:	02/10/2012
Name:	Top 50 BH Prescribers by Reimbursement	Last Revised:	02/20/2012
Group:	Pharmacy	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provide a report the top 50 prescribers of behavioral health drugs ranked by amount of reimbursement paid by MCOs for behavioral health drugs dispensed as defined by behavioral health drug list.

Sample Layout:

	Prescriber Name	NPI Number
1		
2		
3		
4		
5		

Reporting Criteria:

Row Label	Description
Columns 1-50	Ranking from 1 = most quantity to 50 = least quantity

Column Label	Description

Prescriber name	The name of the prescriber who ranks to the corresponding number
NPI Number	The NPI number which corresponds to the prescriber in the second column

Report #:	43	Created:	02/10/2012
Name:	Top 50 Controlled Drugs by Quantity Reimbursed	Last Revised:	
Group:	Pharmacy	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should provide a report the top 50 controlled drugs ranked by quantity reimbursed for controlled drugs dispensed.

Sample Layout:

	Drug Name/Strength/Dosage Form	Cost/Month
1		
2		
3		
4		
5		

Reporting Criteria:

Row Label	Description
Columns 1-50	Ranking from 1 = most quantity to 50 = least quantity

Column Label	Description
Drug Name/Strength/Dosage Form	Name of Drug, Strength of Drug, and Dosage Form of Drug
Cost/Month	The total cost (reimbursement) for the ranked drug for specified time period

Report #:	44	Created:	02/10/2012
Name:	Top 50 Drugs by MCO Reimbursement	Last Revised:	
Group:	Pharmacy	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provide a report the top 50 drugs ranked by MCO reimbursement for drugs dispensed.

Sample Layout:

	Drug Name/Strength/Dosage Form	Cost/Month
1		
2		
3		
4		
5		

Reporting Criteria:

Row Label	Description
Columns 1-50	Ranking from 1 = most quantity to 50 = least quantity

Column Label	Description
Drug Name/Strength/Dosage Form	Name of Drug, Strength of Drug, and Dosage Form of Drug
Cost/Month	The total cost (reimbursement) for the ranked drug for specified time period

Report #:	45A	Created:	02/10/2012
Name:	Top 50 Drugs by Quantity	Last Revised:	
Group:	Pharmacy	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should provide a report the top drugs ranked by quantity reimbursed for drugs dispensed.

Sample Layout:

	Drug Name/Strength/Dosage Form	Cost/Month
1		
2		
3		
4		
5		

Reporting Criteria:

Row Label	Description
Columns 1-50	Ranking from 1 = most quantity to 50 = least quantity

Column Label	Description
Drug Name/Strength/Dosage Form	Name of Drug, Strength of Drug, and Dosage Form of Drug
Cost/Month	The total cost (reimbursement) for the ranked drug for specified time period

Report #:	45B	Created:	02/10/2012
Name:	Top 50 Non PDL Drugs by Reimbursement	Last Revised:	
Group:	Pharmacy	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should provide a report the top 50 Non PDL drugs ranked by reimbursement for Non PDL drugs dispensed.

Sample Layout:

	Drug Name/Strength/Dosage Form	Cost/Month
1		
2		
3		
4		
5		

Reporting Criteria:

Row Label	Description
Columns 1-50	Ranking from 1 = most quantity to 50 = least quantity

Column Label	Description
Drug Name/Strength/Dosage Form	Name of Drug, Strength of Drug, and Dosage Form of Drug
Cost/Month	The total cost (reimbursement) for the ranked drug for specified time period

Report #:	48	Created:	01/09/2012
Name:	Organizational Changes	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Identify any organization changes relating to the MCO during the report period.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 48: Organizational Changes

MCO Name:	**DMS Use Only**
Report Date:	Received Date:
Report Period From:	Reviewed Date:
Report Period To:	Reviewer:

I. Organizational Change

II. Organizational Change

III. Organizational Change

Report #:	49	Created:	01/09/2012
Name:	Administrative Changes	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Identify any administrative changes relating to the MCO during the report period.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 49: Administrative Changes

MCO Name:	**DMS Use Only**
Report Date:	Received Date:
Report Period From:	Reviewed Date:
Report Period To:	Reviewer:

II. Administrative Change

III. Administrative Change

IV. Administrative Change

Report #:	51	Created:	01/09/2012

Name:	Operational Changes	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Identify any operational changes or relevant to the operations of the MCO not otherwise covered during the report period.

Sample Layout:

Kentucky Department for Medicaid Services
MCO Report # 51: Operational Changes

MCO Name:
Report Date:
Report Period From:
Report Period To:

DMS Use Only
Received Date:
Reviewed Date:
Reviewer:

I. Operational Change

II. Operational Change

III. Operational Change

Report #:	52	Created:	02/14/2012
Name:	Expenditures Related to MCO's Operations	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should provide the Executive Management's salary, bonus, other compensation, travel and other expenses based upon the reporting period.

Sample Layout:

							Reporting Period	
Category	Positions	Salary	Bonus	Other Compensation	Travel	Other Expenses	Begin Date	End Date

Executive Management	Executive Officer/CEO							
Executive Management	Medical Director							
Executive Management	Pharmacy Director							
Executive Management	Dental Director							
Executive Management	CFO							
Executive Management	Compliance Director							
Executive Management	Quality Improvement Director							
Executive Management	Sub-Total							
Executive	All other Executives							

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Executive Management	Capable and responsible for the oversight of the entire operation.
Executive Director/CEO	Primary contact and will be authorized to represent the Contractor regarding inquiries pertaining to the contract, will be available during normal business hours, and will have decision-making authority in regard to urgent situations that arise.
Medical Director	Actively involved in all major clinical programs and Quality Improvement components.
Pharmacy Director	Coordinate, manage and oversee the provision of pharmacy services to Members.
Dental Director	Actively involved in all major dental programs.
CFO	Ensure compliance with adopted standards and review expenditures for reasonableness and necessity.
Compliance Director	Maintain current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to Contractor and oversee the Contractor's compliance with the laws and Contract requirements of the Department. serve as the primary contact for and facilitate communications between Contractor leadership and the Department relating to Contract compliance issues.
Quality Improvement Director	Responsible for the operation of the Contractor's QAPI Program and any QAPI Program of its subcontractors.
Sub-Total	Provide the subtotal of each of the Executive Management team above
All Other Executives	Provide a total of all other Executive Management as defined in the MCO contract.

Column Label	Description
Salary	Provide the salary of only the Kentucky's line of business. MCO may disclose an estimated allocation based on the time allocated to Kentucky. Information related to the Contractor's ultimate parent company's Executive Management need not be disclosed.
Bonus	Unless guaranteed, or actually paid during the report period, bonuses disclosed may be target amounts for the period disclosed expressed as a percentage of base salary.
Other Compensation	Is limited to other cash compensation actually paid during the reporting period, and may exclude amounts realized or realizable during the period through grant, vesting or exercise of stock options, restricted stock, stock appreciation rights, phantom stock plans, or other long term non-cash incentives.
Travel	Provide the travel of only the Kentucky's line of business. MCO may disclose an estimated allocation based on the time allocated to Kentucky. Information related to the Contractor's ultimate parent company's Executive Management need not be disclosed.
Other Expenses	Provide the other expenses of only the Kentucky's line of business. MCO may disclose an estimated allocation based on the time allocated to Kentucky. Information related to the Contractor's ultimate parent company's Executive Management need not be disclosed.
Begin Date	Provide the begin date of the report period.
End Date	Provide the end date of the report period.

Report #:	53	Created:	09/12/2011
Name:	Prompt Payment	Last Revised:	09/24/2011
Group:	Financial and Information Systems	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	In accordance with DOI requirements.		
Due Date:	Date Submitted to DOI		
Submit To:	Kentucky Department of Insurance Kentucky Department for Medicaid Services		

Description:

MCOs are required to comply with the Kentucky Department of Insurance (DOI) requirements for prompt payment reporting as referenced in the DOI HIPMC-CP-3 Prompt Payment Reporting Manual. The DOI requires a quarterly submission of the prompt payment report. A copy of the quarterly prompt payment report is required to be submitted to the Department for Medicaid Services (DMS) at the same time the report is submitted to the DOI. Any revisions of the documents submitted to the DOI are also to be submitted to the DMS at the same time.

Report #:	54	Created:	08/28/2011
Name:	COB Savings	Last Revised:	09/10/2011
Group:	Third Party Liability	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Reports all Coordination of Benefit (COB) savings due to other insurance payment, including Medicare, for which the claim submission includes and the MCO processed/paid the claim accordingly. The report is to include claims when the other insurance paid zero dollars because the service was not covered by the other insurance.

Sample Layout:

COB/TPL Savings									
Claim ICN	Provider ID	Provider Name	Member Medicaid ID	Member Name	MCO Paid Amount	COB Amount	Other Insurance Deductible Amount	Other Insurance Co-Insurance Amount	Paid Date
Total					$0.00	$0.00	$0.00	$0.00	

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'Paid Date'.

Row Label	Description
Total	Provide a total of all reported activity for MCO Paid Amount, COB Amount, Other Insurance Deductible Amount and Other Insurance Co-Pay Amount.

Column Label	Description
Claim ICN	The MCO claim internal control number for the claim being reported.
Provider ID	Medicaid Provider ID reported as a text string.
Provider Name	Concatenate the Provider's 'Last Name', 'First Name' 'Middle Initial'.
Member Medicaid ID	The Member's Medicaid ID
Member Name	Concatenate the Member's 'Last Name', 'First Name' 'Middle Initial'.
MCO Paid Amount	The net amount the claim adjudicated to a paid status. Note: When there is a Provider outstanding balance due and the claim payment was reduced by the outstanding balance do not report the payment Financial paid out.
COB Amount	The amount the other insurance paid on the claim.
Other Insurance Deductible Amount	The amount that the other insurance applied to the deductible on the claim. Report $0 if the other insurance did not report a deductible amount.
Other Insurance Co-Insurance Amount	The amount the other insurance applied to the co-insurance on the claim. Report $0 if the other insurance did not report a co-insurance amount.
Paid Date	The date the MCO paid the claim.

Report #:	55	Created:	08/28/2011
Name:	Medicare Cost Avoidance	Last Revised:	09/10/2011
Group:	Third Party Liability	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Reports the Medicare crossover claims that were denied during the reporting period because the claim was submitted without first having been submitted to Medicare for payment.

Sample Layout:

Medicare Cost Avoidance						
Claim ICN	Medicaid Provider ID	Provider Name	Member Medicaid ID	Member Name	Denied Amount	Date Denied
Total					$0.00	

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'Date Denied'.

Row Label	Description
Total	Provide a total of all reported activity for Denied Amount, Medicare Payment, Medicare Deductible and Medicare Coinsurance.

Column Label	Description
Claim ICN	The MCO claim internal control number for the claim being reported.
Medicaid Provider ID	Medicaid Provider ID reported as a text string.
Provider Name	Concatenate the Provider's 'Last Name', 'First Name' 'Middle Initial'.
Member Medicaid ID	The Member's Medicaid ID
Member Name	Concatenate the Member's 'Last Name', 'First Name' 'Middle Initial'.
Denied Amount	The billed amount the MCO denied due to Medicare coverage.
Date Denied	The date the MCO denied/paid $0 for the claim due to Medicare coverage.

Report #:	56	Created:	08/28/2011
Name:	non-Medicare Cost Avoidance	Last Revised:	09/10/2011
Group:	Third Party Liability	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA

Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report lists the claims that were denied during the reporting period because the claim was submitted without first having been submitted to another Insurer for payment. The report is not to include Medicare crossover claims.

Sample Layout:

non-Medicare Cost Avoidance						
Claim ICN	Medicaid Provider ID	Provider Name	Member Medicaid ID	Member Name	Denied Amount	Date Denied
Total					$0.00	

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'Date Denied'

Row Label	Description
Total	Provide a total of all reported activity for Denied Amount, Other Insurance non-Medicare Payment, Other Insurance non-Medicare Deductible and Other Insurance non-Medicare Coinsurance.

Column Label	Description
Claim ICN	The MCO claim internal control number for the claim being reported.
Medicaid Provider ID	Medicaid Provider ID reported as a text string.
Provider Name	Concatenate the Provider's 'Last Name', 'First Name' 'Middle Initial'.
Member Medicaid ID	The Member's Medicaid ID
Member Name	Concatenate the Member's 'Last Name', 'First Name' 'Middle Initial'.
Denied Amount	The billed amount the MCO denied due to Medicare coverage.
Date Denied	The date the MCO denied/paid $0 for the claim due to the other non-Medicare insurance coverage.

Report #:	57	Created:	08/27/2011
Name:	Potential Subrogation	Last Revised:	08/29/2011
Group:	Third Party Liability	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		

Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provides report for cases where the MCO's Member has had an accident and there is potential for a liable third party or subrogation claim.

Sample Layout:

Potential Subrogation/Liable Party									
Member Name	Member Medicaid ID	Date of Injury	Subrogation/Liable Party Indicator	Attorney/Member Letter Sent Date	Attorney/Liable Party Information	Lien/Claim Amount	Recovered Amount	State Notified	Date Closed

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'Member Name'.

Row Label	Description
NA	NA

Column Label	Description
Member Name	Concatenate the Medicaid Member's 'Last Name', 'First Name', 'Middle Initial'
Member Medicaid ID	The Member's Medicaid ID reported as a text string.
Date of Injury	The date of the actual injury/accident.
Subrogation/Liable Party Indicator	Valid values are S for Subrogation or LP for Liable Party
Attorney/Member Letter Sent Date	This is the date that either an attorney or Member letter is sent.
Attorney/Liable Party Information	The attorney/liable party name, address and contact information.
Lien Claim Amount	The MCO lien or claim amount.
Recovered Amount	The MCO recovered amount from the attorney/liable party.
State Notified	Value of Y if DMS is notified of a claim.
Date Closed	The date the case is closed due to either recovery or no case.

Report #:	58	Created:	08/20/2011
Name:	Original Claims Processed	Last Revised:	08/29/2011
Group:	Claims Processing	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, B
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provides the number of original clean claims processed during a reporting period reported by Billing Provider Type and claim status. There are four claim statuses to be included in the report:

1. Received;
2. Pay;
3. Deny; and
4. Suspended

Two (2) Billing Provider Types are further broken down as follows:

3. Billing Provider Type 01 General Hospital
    a. Inpatient;
    b. Outpatient;
    c. Emergency Room; and
    d. Inpatient/Outpatient Other
4. Billing Provider Type 54 Pharmacy
    a. Pharmacy non-Behavioral Health Brand;
    b. Pharmacy non-Behavioral Health Generic;
    c. Pharmacy Behavioral Health Brand; and
    d. Pharmacy Behavioral Health Generic

Sample Layout:

	Claims Received			
	Total Count	Total Processed	Total Charges	Avg. Charges
Total All Claims				
Inpatient				
Outpatient				
Emergency Room				
Inpatient/Outpatient Other				
Mental Hospital				
PRTF				
Specialized Child Svc Clinics				

	Adjudicated to Pay Status					
	Total Count	Percent	Total Charges	Avg. Charges	Total Paid	Avg. Paid
Total All Claims						
Inpatient						
Outpatient						
Emergency Room						
Inpatient/Outpatient Other						
Mental Hospital						
PRTF						

Specialized Child Svc Clinics						

	Adjudicated to Deny Status			
	Total Count	Percent	Total Charges	Avg. Charges
Total All Claims				
Inpatient				
Outpatient				
Emergency Room				
Inpatient/Outpatient Other				
Mental Hospital				
PRTF				
Specialized Child Svc Clinics				

	Placed in Suspended Status			
	Total Count	Percent	Total Charges	Avg. Charges
Total All Claims				
Inpatient				
Outpatient				
Emergency Room				
Inpatient/Outpatient Other				
Mental Hospital				
PRTF				
Specialized Child Svc Clinics				

Reporting Criteria:

General Specifications	Definition
Claim	Claim is defined as an original clean claim.
Claim Count	A claim count of one is applied to each claim. Therefore a claim that pays on the header and a claim that pays on the detail will both have a count of one.
Billing Provider Type	Billing Provider Type is designated with a state specific two (2) character field. Example: Billing Provider Type 01 = General Hospital
Provider Type Category	Billing Provider Type Category is a breakdown of a Billing Provider Type by specified criteria.
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
Total All Claims	Includes all Provider Types and Provider Type Categories included in the report.
'Provider Type'	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk.
'Provider Type Category'	Crosswalk of Provider Type Categories for General Hospital and

	Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Other non-Medicaid Provider Type	Category is used to report claims processed for Providers that do not have a Medicaid Provider ID or for Providers with a Provider Type that Medicaid does not recognize.

Claim Status	Column Label	Description
Received	Total Count	Total Count of all Original Claims received during the reporting period.
Received	Total Processed	Total Count of all Original Claims processed during the reporting period to a status of Pay, Deny or Suspended.
Received	Total Charges	Total charges for all received original claims. A claim that pays at the header should use the charges from the header. A claim that pays at the detail should include the charges from all the details.
Received	Avg. Charges	Calculated Field: 'Total Charges' from received status divided 'Total Count' from received status.
Pay	Total Count	Total Count of all Original Claims received during the reporting period that adjudicated to a Pay status.
Pay	Percent	Calculated Field: 'Total Count' from pay status divided by 'Total Count' from received status.
Pay	Total Charges	Total charges from original claims adjudicated to a pay status. Header paid claims will use the charges from the Header. Detail paid claims will use charge from the line items that have a pay status. Denied line item charges are not to be included in Total Charges.
Pay	Avg. Charges	Calculated Field: 'Total Charges' from pay status divided by 'Total Count' from pay status.
Pay	Total Paid	The total adjudicated claim paid amount by the MCO. Example: A claim adjudicated to pay $100. There is an outstanding A/R in financial for $200. The MCO should report the $100 adjudicated paid amount and not the $0 financial payment.
Pay	Avg. Paid	Calculated Field: 'Total Paid' from pay status divided by 'Total Count' from pay status.
Deny	Total Count	Total Count of all Original Claims received during the reporting period that adjudicated to a Deny status.
Deny	Percent	Calculated Field: 'Total Count' from deny status divided by 'Total Count' from received status.
Deny	Total Charges	Total charges for all denied original claims. A claim that pays at the header should use the charges from the header. A claim that pays at the detail should include the charges from all the details.
Deny	Avg. Charges	Calculated Field: 'Total Charges' from deny status divided by 'Total Count' from deny status.
Suspended	Total Count	Total Count of all Original Claims received during the reporting period that moved to a suspended status. The claim shall be counted even if the claim later was changed to a Pay or Deny status during the reporting period.
Suspended	Percent	Calculated Field: 'Total Count' from suspended status divided by 'Total Count' from received status.
Suspended	Total Charges	Total charges for all suspended original claims. A claim that pays at the header should use the charges

		from the header. A claim that pays at the detail should include the charges from all the details.
Suspended	Avg. Charges	Calculated Field: 'Total Charges' from suspended status divided by 'Total Count' from suspended status.

Report #:	59	Created:	09/10/2011
Name:	Prior Authorizations	Last Revised:	10/06/2011
Group:	Medical Management	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, B
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report list the Prior Authorization (PA) activity during the reporting period. All PAs required by the MCO are to be listed regardless of the level of activity during the reporting period. If an MCO adds or deletes a PA from their program requirements then the MCO is to report that information when submitting the report.

Sample Layout:

Prior Authorization (PA)								
Provider Type/Category	Prior Authorizations Requested	Prior Authorizations Approved			Prior Authorizations Partial Approved			Prior Authorizations Denied
		Medical Necessity (no MCO Service Limits)	Medical Necessity and within MCO Service Limits	Medical Necessity and Exceeded MCO Service Limits	Medical Necessity (no MCO Service Limits)	Medical Necessity and within MCO Service Limits	Medical Necessity and Exceeded MCO Service Limits	
Inpatient								
Outpatient								
Emergency Room								
Inpatient/Outpatient Other								
Mental Hospital								
Other non-Medicaid Provider Type								
Total	0	0	0	0	0	0	0	0

Prior Authorization (PA)										
Provider Type/Category	Prior Authorization Units									
	Approved			Partially Approved			Partially Denied			Denied
	Medical Necessity (no MCO Service Limits)	Medical Necessity and within MCO Service Limits	Medical Necessity and Exceeded MCO Service Limits	Medical Necessity (no MCO Service Limits)	Medical Necessity and within MCO Service Limits	Medical Necessity and Exceeded MCO Service Limits	Medical Necessity (no MCO Service Limits)	Medical Necessity and within MCO Service Limits	Medical Necessity and Exceeded MCO Service Limits	

Inpatient										
Outpatient										

Total	0	0	0	0	0	0	0	0	0	0

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
'Provider Type'	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk.
'Provider Type Category'	Crosswalk of Provider Type Categories for General Hospital and Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Other non-Medicaid Provider Type	Category is used to report prior authorizations processed for Providers that do not have a Medicaid Provider ID or for Providers with a Provider Type that Medicaid does not recognize.
Total	Report the total of all PA activity listed in the report.

Column Label	Description
Prior Authorizations Requested	The total number of prior authorizations that were requested for each specific 'Provider Type/Category'. If no PA activity was requested for a specific 'Provider Type/Category' report 0.
Prior Authorizations Approved	The total number of prior authorizations that were approved for each specific "Provider Type/Category'. If no PA activity was requested for a specific 'Provider Type/Category' report 0.
PAs Approved: Medical Necessity (no MCO service Limits)	Prior authorizations required for medical necessity determination only. There are no MCO service limits for the service being prior authorized and the MCO approved all of the units requested.
PAs Approved: Medical Necessity and within MCO Service Limits	The MCO has service limits and a medical necessity determination for the service that is being prior authorized. Only report the prior authorizations if the MCO approved all of the units requested and the units approved did not exceed MCO service limits.
PAs Approved: Medical Necessity and Exceeded MCO Service Limits	The MCO has service limits and a medical necessity determination for the service that is being prior authorized. Only report the prior authorizations if the MCO approved all of the units requested and the total units approved exceeded the MCO service limits.
Prior Authorizations Partially Approved	The total number of prior authorizations that were partially approved for each specific "Provider Type/Category'. If no PA activity was requested for a specific 'Provider Type/Category' report 0.
PAs Partially Approved: Medical Necessity (no MCO service Limits)	Prior authorizations required for medical necessity determination only. There are no MCO service limits for the service being prior authorized and the MCO approved some but not all of the units requested.
PAs Partially Approved: Medical Necessity and within MCO Service Limits	The MCO has service limits and a medical necessity determination for the service that is being prior authorized. Only report the prior authorizations if the MCO approved some but not all of the units requested and the units

	approved did not exceed MCO service limits.
PAs Partially Approved: Medical Necessity and Exceeded MCO Service Limits	The MCO has service limits and a medical necessity determination for the service that is being prior authorized. Only report the prior authorizations if the MCO approved some but not all of the units requested and the total units approved exceeded the MCO service limits.
Prior Authorizations Denied	The total number of prior authorizations that were denied for each specific "Provider Type/Category'. If no PA activity was requested for a specific 'Provider Type/Category' report 0.
Prior Authorization Units	The total number of units of service that meet the specified criteria.
PA Units: Approved	The total number of prior authorization units associated with prior authorizations that were approved.
PA Units: Approved: Medical Necessity (no MCO service Limits)	Total units approved based on medical necessity determination only. There are no MCO service limits for the service being prior authorized and the MCO approved all of the units requested.
PA Units: Approved: Medical Necessity and within MCO Service Limits	Total units approved based on MCO service limits and a medical necessity determination. Only report if the MCO approved all of the units requested and the units approved did not exceed MCO service limits.
PA Units: Approved: Medical Necessity and Exceeded MCO Service Limits	Total units approved based on MCO service limits and a medical necessity determination. Only report if the MCO approved all of the units requested and the total units approved exceeded the MCO service limits.
PA Units: Partially Approved	The total number of prior authorization units approved associated with prior authorizations that were partially approved. If no PA activity was requested for a specific 'Provider Type/Category' report 0.
PA Units: Partially Approved: Medical Necessity (no MCO service Limits)	Total units approved based on medical necessity determination only. There are no MCO service limits for the service being prior authorized and the MCO approved some but not all of the units requested.
PA Units: Partially Approved: Medical Necessity and within MCO Service Limits	Total units approved based on MCO service limits and a medical necessity determination. Only report if the MCO approved some but not all of the units requested and the units approved did not exceed MCO service limits.
PA Units: Partially Approved: Medical Necessity and Exceeded MCO Service Limits	Total units approved based on MCO service limits and a medical necessity determination. Only report if the MCO approved some but not all of the units requested and the total units approved exceeded the MCO service limits.
PA Units: Partially Denied	The total number of prior authorization units denied associated with prior authorizations that were partially approved. If no PA activity was requested for a specific 'Provider Type/Category' report 0.
PA Units: Partially Denied: Medical Necessity (no MCO service Limits)	Total units denied based on medical necessity determination only. There are no MCO service limits for the service being prior authorized and the MCO denied some but not all of the units requested.
PA Units: Partially Denied: Medical Necessity and within MCO Service Limits	Total units denied based on MCO service limits and a medical necessity determination. Only report if the MCO denied some but not all of the units requested and the units approved did not exceed MCO service limits.
PA Units: Partially Denied: Medical Necessity and Exceeded MCO Service Limits	Total units denied based on MCO service limits and a medical necessity determination. Only report if the MCO denied some but not all of the units requested and the total units approved exceeded the MCO service limits.
PA Units: Denied	The total number of prior authorization units associated with prior authorizations that were denied.

Report #:	60	Created:	08/20/2011
Name:	Original Claims Payment Activity	Last Revised:	08/29/2011

Group:	Claims Processing	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, B
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provides the number of original clean claims paid during a reporting period reported by Billing Provider Type and length of time from receipt of a clean original claim to claim payment. Two (2) Billing Provider Types are further broken down as follows:

Billing Provider Type 01 General Hospital
- Inpatient
- Outpatient
- Emergency Room
- Inpatient/Outpatient Other

Billing Provider Type 54 Pharmacy
- Pharmacy non-Behavioral Health Brand
- Pharmacy non-Behavioral Health Generic
- Pharmacy Behavioral Health Brand
- Pharmacy Behavioral Health Generic

Sample Layout:

	Original Paid Claims from Date of Receipt				
	1-30 Days	31-60 Days	61-90 Days	91+ Days	Total Claims
Total All Claims					
Inpatient					
Outpatient					
Emergency Room					
Inpatient/Outpatient Other					
Mental Hospital					
PRTF					
Specialized Child Svc Clinics					

Reporting Criteria:

General Specifications	Definition
Claim	Claim is defined as an original clean claim that has been paid.
Claim Count	A claim count of one is applied to each paid claim. Therefore a header paid claim and a detail paid claim will both have a count of one.
Billing Provider Type	Billing Provider Type is designated with a state specific two (2) character field. Example: Billing Provider Type 01 = General Hospital
Provider Type Category	Billing Provider Type Category is a breakdown of a Billing Provider Type by specified criteria.
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
Total All Claims	Includes all Provider Types and Provider Type Categories included in the

	report.
'Provider Type'	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk.
'Provider Type Category'	Crosswalk of Provider Type Categories for General Hospital and Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Other non-Medicaid Provider Type	Category is used to report claims processed for Providers that do not have a Medicaid Provider ID or for Providers with a Provider Type that Medicaid does not recognize.

Column Label	Description
1-30 Days	Total count of all claims paid during the reporting period for which the claim was in process for 1 to 30 calendar days from receipt of a clean claim.
31-60 Days	Total count of all claims paid during the reporting period for which the claim was in process for 31 to 60 calendar days from receipt of a clean claim.
61-90 Days	Total count of all claims paid during the reporting period for which the claim was in process for 61 to 90 calendar days from receipt of a clean claim.
91+ Days	Total count of all claims paid during the reporting period for which the claim was in process for 91 or more 30 calendar days from receipt of a clean claim.
Total Claims	Total count of all claims paid during the reporting period.

Report #:	61	Created:	08/20/2011
Name:	Denied Claims Activity	Last Revised:	08/29/2011
Group:	Claims Processing	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, B
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provides the number of original clean claims denied during a reporting period reported by Billing Provider Type and length of time from receipt of a clean original claim to claim denial. Two (2) Billing Provider Types are further broken down as follows:

Billing Provider Type 01 General Hospital
- Inpatient
- Outpatient
- Emergency Room
- Inpatient/Outpatient Other

Billing Provider Type 54 Pharmacy
- Pharmacy non-Behavioral Health Brand
- Pharmacy non-Behavioral Health Generic
- Pharmacy Behavioral Health Brand
- Pharmacy Behavioral Health Generic

Sample Layout:

	Denied Claims from Date of Receipt				
	1-30 Days	31-60 Days	61-90 Days	91+ Days	Total Claims
Total All Claims					
Inpatient					
Outpatient					
Emergency Room					
Inpatient/Outpatient Other					
Mental Hospital					
PRTF					
Specialized Child Svc Clinics					

Reporting Criteria:

General Specifications	Definition
Claim	Claim is defined as an original clean claim that has been denied.
Claim Count	A claim count of one is applied to each denied claim. Therefore a header paid claim that is denied and a detailed paid claim that is denied on all details will both have a count of one.
Billing Provider Type	Billing Provider Type is designated with a state specific two (2) character field. Example: Billing Provider Type 01 = General Hospital
Provider Type Category	Billing Provider Type Category is a breakdown of a Billing Provider Type by specified criteria.
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
Total All Claims	Includes all Provider Types and Provider Type Categories included in the report.
'Provider Type'	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk.
'Provider Type Category'	Crosswalk of Provider Type Categories for General Hospital and Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Other non-Medicaid Provider Type	Category is used to report claims processed for Providers that do not have a Medicaid Provider ID or for Providers with a Provider Type that Medicaid does not recognize.

Column Label	Description
1-30 Days	Total count of all claims denied during the reporting period for which the claim was in process for 1 to 30 calendar days from receipt of a clean claim.
31-60 Days	Total count of all claims denied during the reporting period for which the claim was in process for 31 to 60 calendar days from receipt of a clean claim.
61-90 Days	Total count of all claims denied during the reporting period for which the claim was in process for 61 to 90 calendar days from receipt of a clean claim.

91+ Days	Total count of all claims denied during the reporting period for which the claim was in process for 91 or more calendar days from receipt of a clean claim.
Total Claims	Total count of all claims denied during the reporting period.

Report #:	62	Created:	08/20/2011
Name:	Suspended Claims Activity	Last Revised:	08/29/2011
Group:	Claims Processing	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, B
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Provides the number of original clean claims in a suspended status during a reporting period reported by Billing Provider Type and length of time from receipt of an original claim. Two (2) Billing Provider Types are further broken down as follows:

Billing Provider Type 01 General Hospital
- Inpatient
- Outpatient
- Emergency Room
- Inpatient/Outpatient Other

Billing Provider Type 54 Pharmacy
- Pharmacy non-Behavioral Health Brand
- Pharmacy non-Behavioral Health Generic
- Pharmacy Behavioral Health Brand
- Pharmacy Behavioral Health Generic

Sample Layout:

	Number of Days Claims Suspended				
	1-30 Days	31-60 Days	61-90 Days	91+ Days	Total Claims
Total All Claims					
Inpatient					
Outpatient					
Emergency Room					
Inpatient/Outpatient Other					
Mental Hospital					
PRTF					
Specialized Child Svc Clinics					

Reporting Criteria:

General Specifications	Definition
Claim	Claim is defined as an original clean claim that has been suspended.
Claim Count	A claim count of one is applied to each suspended claim. Therefore a header paid claim that is suspended and a detailed paid claim that is suspended will both have a count of one.
Billing Provider Type	Billing Provider Type is designated with a state specific two (2) character field. Example: Billing Provider Type 01 = General Hospital
Provider Type Category	Billing Provider Type Category is a breakdown of a Billing Provider Type by specified criteria.
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
Total All Claims	Includes all Provider Types and Provider Type Categories included in the report.
'Provider Type'	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk.
'Provider Type Category'	Crosswalk of Provider Type Categories for General Hospital and Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Other non-Medicaid Provider Type	Category is used to report claims processed for Providers that do not have a Medicaid Provider ID or for Providers with a Provider Type that Medicaid does not recognize.

Column Label	Description
1-30 Days	Total count of all claims in a suspended status during the reporting period for which the claim was suspended for 30 or fewer calendar days.
31-60 Days	Total count of all claims in a suspended status during the reporting period for which the claim was suspended for a total of 31 to 60 calendar days.
61-90 Days	Total count of all claims in a suspended status during the reporting period for which the claim was suspended for a total of 61 to 90 calendar days.
91+ Days	Total count of all claims in a suspended status during the reporting period for which the claim was suspended for 91 calendar days or more.
Total Claims	Total count of all claims in a suspended status during the reporting period.

Report #:	63	Created:	10/10/2011
Name:	Claims Inventory	Last Revised:	12/12/2011
Group:	Claims Processing	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	Previous Two (2) Quarters		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Claims Inventory report provides the count of clean claims that exceed processing timeliness standards. Only original claims are to be included. Claims for capitation, adjustments and pharmacy reversals are not to be included in the report. Individual reports from the MCO and the MCO subcontractors that adjudicate claims are to be provided.

Timeliness standards are defined as 90% of all Provider Claims for which no further written information or substantiation is required in order to make payment are paid or denied within 30 days of the date of receipt of such claims and that 99% of all claims are processed within 90 days of the date of the receipt of such claims.

Sample Layout:

Received Date	ICN Julian Date	Total Claims(Paid + Denied + Suspended)	Total Paid	Total Denied	Total Suspended	Paid/ Denied in 7 days or less	Paid/ Denied in 8 to 14 days	Paid/ Denied in 15 to 21 days	Paid/ Denied in 22 to 29 days	Paid/ Denied in 30 days or less	Paid/ Denied in 90 days or less	Paid/ Denied > 90 days

Received Date	ICN Julian Date	Total Claims(Paid + Denied + Suspended)	Total Paid	Total Denied	Total Suspended	Paid/ Denied in 7 days or less	Paid/ Denied in 8 to 14 days	Paid/ Denied in 15 to 21 days	Paid/ Denied in 22 to 29 days	Paid/ Denied in 30 days or less	Paid/ Denied in 90 days or less	Paid/ Denied > 90 days

Reporting Criteria:

General Specifications	Definition
Claim Count	A claim count of one is applied to each claim. Therefore a claim that pays on the header and a claim that pays on the detail will both have a count of one.
Clean Claim	A claim for which no further written information or substantiation is required in order to make payment.

Date Format	All report dates are to be in the following format: mm/dd/yyyy
Due Date	Reports are due on the following dates: 15-APR, 15-JUL, 15-OCT, 15-JAN. If the Due Date falls on a non-business day then the report will be due the next business day.
Suspended Claims	Regardless of the reason for the claim suspension, all suspended claims are to be measured using the received date of the claim for purposes of meeting timeliness standards.

Row Label	Description
NA	NA

Column Label	Description
Received Date	The date that the claim was received. Received dates are to start two quarters prior to the month the report due or the effective start date of the MCO or MCO subcontractor whichever is most recent and end with the last day of the reporting period. Example 1: MCO claims processing. MCO start date was 01-NOV-2011. Report Due on 15-JAN-2013. Reporting Period would be from 01-Jul-2012 through 31-DEC-2012. The first 'Received Date' reported would be 07/01/2012 and the last 'Received Date' reported would be 12/31/2012. Example 2: MCO subcontractor claims processing. Subcontractor start date was 01-JUL-2012. Report Due on 15-OCT-2012. Reporting Period would be from 01-JUL-2012 through 30-SEP-2012. The first 'Received Date' reported would be 07/01/2012 and the last 'Received Date' reported would be 09/30/2012.
ICN Julian Date	Kentucky includes the Julian date that the claim was received as part of the claim Internal control Number (ICN). If the MCO or the MCO subcontractor does not include the Julian date in their ICNs then populate this field with the 'Received Date' formatted as a Julian Date.
Total Claims (Paid + Denied + Suspended)	For each 'Received Date' listed on the report provide a total claim count for all original claims received. Claims for capitation, adjustments and pharmacy reversals are not to be included in the counts.
Total Paid	For each 'Received Date' listed on the report provide a total claim count for all original claims that have been paid as of the run date of the report. Claims for capitation, adjustments and pharmacy reversals are not to be included in the counts.
Total Denied	For each 'Received Date' listed on the report provide a total claim count for all original claims that have been denied as of the run date of the report. Claims for capitation, adjustments and pharmacy reversals are not to be included in the counts.
Total Suspended	For each 'Received Date' listed on the report provide a total claim count for all original claims that remain in a suspended status as of the run date of the report. Claims for capitation, adjustments and pharmacy reversals are not to be included in the counts.
Paid/Denied in 7 days or less (Paid/Denied Claim Counts)	For each 'Received Date' listed on the report provide a total claim count for all original claims that have been paid or denied within seven (7) days or less from the 'Received Date'. Claims for capitation, adjustments and pharmacy reversals are not to be included in the counts.
Paid/Denied in 8 to 14 days (Paid/Denied Claim Counts)	For each 'Received Date' listed on the report provide a total claim count for all original claims that have been paid or denied within eight (8) to fourteen (14) days from the 'Received Date'. Claims for capitation, adjustments and pharmacy reversals are not to be included in the counts.
Paid/Denied in 15 to 21 days	For each 'Received Date' listed on the report provide a total claim count

(Paid/Denied Claim Counts)	for all original claims that have been paid or denied within fifteen (15) to twenty-one (21) days from the 'Received Date'. Claims for capitation, adjustments and pharmacy reversals are not to be included in the counts.
Paid/Denied in 22 to 29 days (Paid/Denied Claim Counts)	For each 'Received Date' listed on the report provide a total claim count for all original claims that have been paid or denied within twenty-two (22) to twenty-nine (29) days from the 'Received Date'. Claims for capitation, adjustments and pharmacy reversals are not to be included in the counts.
Paid/Denied in 30 days or less (Percentage of Paid/Denied)	Calculated field determined by dividing the 'Paid/Denied in 30 days or less (Paid/Denied Claim Counts)' value by the 'Total Claims (Paid + Denied + Suspended)' value for each 'Received Date' listed on the report.
Paid/Denied in 90 days or less (Percentage of Paid/Denied)	Calculated field determined by dividing the 'Paid/Denied in 90 days or less (Paid/Denied Claim Counts)' value by the 'Total Claims (Paid + Denied + Suspended)' value for each 'Received Date' listed on the report.
Paid/Denied > 90 days (Percentage of Paid/Denied)	Calculated field determined by dividing the 'Paid/Denied > 90 days (Paid/Denied Claim Counts)' value by the 'Total Claims (Paid + Denied + Suspended)' value for each 'Received Date' listed on the report.

Report #:	65	Created:	02/13/2012
Name:	Foster Care	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services Kentucky Department for Community Based Services		

Description:

Monthly report provides information on the Foster Care population for each MCO and broken down by Region.

Sample Layout:

MCO Region	Foster Care Region	Number of New Foster Care Members	Number of Existing Foster Care Members	Number of New Foster Care Members Enrolled into CM	Number of Existing Foster Care Members Enrolled into CM	Number of New Foster Care Members Enrolled into DM	Number of Existing Foster Care Members Enrolled into DM	Number of New Foster Care Members with Completed HRAs	Number of Existing Foster Care Members with Completed HRAs

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in order: MCO Region

Row Label	Description
NA	NA

Column Label	Description
MCO Region	Provide the member's MCO region.
Foster Care Region	Provide the member's Foster Care region.
Number of New Foster Care Members	Provide the total number of new Foster Care Members during the month.
Number of Existing Foster Care Members	Provide the total number of existing Foster Care Members during the month.
Number of New Foster Care Members Enrolled into Case Management	Provide the total number of new Foster Care Members enrolled into Case Management during the month.
Number of Existing Foster Care Members Enrolled into Case Management	Provide the total number of existing Foster Care Members enrolled into Case Management during the month.
Number of New Foster Care Member Enrolled into Disease Management	Provide the total number of new Foster Care Members enrolled into Disease Management during the month.
Provide the total number of Existing Foster Care Members enrolled into Disease Management	Provide the total number of existing Foster Care Members enrolled into Disease Management during the month.
Number of New Foster Care Members with Completed HRAs	Provide the total number of new Foster Care Members with completed HRAs during the month.
Number of Existing Foster Care Members with Completed HRAs	Provide the total number of existing Foster Care Members enrolled into HRAs during the month.

Report #:	66	Created:	02/10/2012
Name:	Guardianship	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services Kentucky Department for Aging and Independent Living		

Description:

Monthly report provides information on the Guardianship population for each MCO and broken

down by Region.

Sample Layout:

MCO Region	Guardianship Region	Number of New Guardianship Members	Number of Existing Guardianship Members	Number of New Guardianship Members Enrolled into CM	Number of Existing Guardianship Members Enrolled into CM	Number of New Guardianship Members Enrolled into DM	Number of Existing Guardianship Members Enrolled into DM	Number of New Guardianship Members with Completed HRAs	Number of Existing Guardianship Members with Completed HRAs

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in order: MCO Region

Row Label	Description
NA	NA

Column Label	Description
MCO Region	Provide the member's MCO region.
Guardianship Region	Provide the member's Guardianship region.
Number of Guardianship Members	Provide the total number of new Guardianship Members during the month.
Number of Existing Guardianship Members	Provide the total number of existing Guardianship Members during the month.
Number of New Guardianship Members Enrolled into Case Management	Provide the total number of new Guardianship Members enrolled into Case Management during the month.
Number of Existing Guardianship Members Enrolled into Case Management	Provide the total number of existing Guardianship Members enrolled into Case Management during the month.
Number of New Guardianship Member Enrolled into Disease Management	Provide the total number of new Guardianship Members enrolled into Disease Management during the month.
Provide the total number of Existing Guardianship Members enrolled into Disease Management	Provide the total number of existing Guardianship Members enrolled into Disease Management during the month.
Number of New Guardianship	Provide the total number of new Guardianship Members with completed

Members with Completed HRAs	HRAs during the month.
Number of Existing Guardianship Members with Completed HRAs	Provide the total number of existing Guardianship Members enrolled into HRAs during the month.

Report #:	67	Created:	08/21/2011
Name:	Provider Credentialing Activity	Last Revised:	09/01/2011
Group:	Provider Enrollment	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Report documents by Medicaid Provider Type the activity related to Provider Enrollments, Credentialing and Termination of Providers by the MCO.

Sample Layout:

			Provider Enrollment, Credentialing, Termination Summary				
Provider Type	Provider Type Description	Applications in Process	Applications Received	Applications Credentialed	Applications Processed	Enrolled	Denied
01	General Hospital						
02	Mental Hospital						
04	PRTF						
	Total	0	0	0	0	0	0

Reporting Criteria:

Terminology	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
'Provider Type'	Medicaid defined Provider Type. A Provider may be enrolled under multiple Provider Types.
Total	Calculated Field: Total of activity for all Provider Types listed in the report.

Column Label	Description
Provider Type	Provider Type Code of two characters and is based on Kentucky's recognized Provider Types.
Provider Type Description	Description for Provider Type.
Applications in Process	Total number of applications on hand at the MCO that have not completed the entire MCO enrollment process.
Applications Received	Total number of Provider Applications received by the MCO during the reporting period. If a single Provider is requesting to be credentialed under multiple Provider Types the Application Received is to be reported

	under each Provider Type.
Applications Credentialed	Total number of Provider Applications credentialed during the reporting period. If a single Provider is credentialed under more than one Provider Type the Application Credentialed is to be reported under each Provider Type.
Applications Processed	Total number of Provider Applications Processed to an enrollment or deny status by the MCO during the reporting period. If a single Provider is requesting to be credentialed under multiple Provider Types the Application Processed is to be reported under each Provider Type.
Enrolled	Total number of Providers enrolled by the MCO during the reporting period. Only providers issued a Medicaid Provider ID are to be included in the count for Enrolled. If a single Provider is enrolled under multiple Provider Types the enrollment is to be reported under each Provider Type.
Denied	Total number of Providers denied by the MCO during the reporting period. If a single Provider is denied under multiple Provider Types the denial is to be reported under each Provider Type.

Report #:	69	Created:	08/21/2011
Name:	Termination from MCO Participation	Last Revised:	10/01/2011
Group:	Provider Enrollment	Report Status:	Active
Frequency:	Monthly	Exhibits:	C
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Report documents any Provider of Subcontractor who is suspended or terminated for participation with the MCO. Only those Providers or Subcontractors who had been participating with the MCO are to be reported.

Sample Layout:

Providers or Subcontractors that are Suspended or Terminated for Participation with the MCO													
NPI	KY Medicaid ID	Last /Entity Name	First Name	Title	Phone	Addr. 1	Addr. 2	City	State	Zip	County	Co. Name	Reason

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
NA	NA

Column Label	Description

NPI	NPI should be reported as a text string. When the suspension or termination applies to a Medical Provider then report the Provider's NPI. When the suspension or termination is for a subcontractor then report 'Subcon'.
KY Medicaid ID	For a Provider report the Medicaid ID number assigned by the Department for Medicaid Services. For a subcontractor report NA.
Last/Entity Name	1) When the suspension or termination applies to an individual Medical Provider report the last name of the Provider. 2) When the suspension or termination applies to a Provider group report the group name. 3) When the suspension or termination applies to a subcontractor report the last name of the company contact.
First Name	1) When the suspension or termination applies to an individual Medical Provider report the first name of the Provider. 4) When the suspension or termination applies to a Provider group report the group name. 5) When the suspension or termination applies to a subcontractor report the first name of the company contact.
Title	1) When the suspension or termination applies to an individual Medical Provider report the title of the Provider. 2) When the suspension or termination applies to a Provider Group report 'NA'. 3) When the suspension or termination applies to a subcontractor report the title of the company contact.
Phone	Provide the contact number for the 'Last/Entity Name' listed.
Addr. 1	First line of the mailing address for the 'Last/Entity Name' listed.
Addr. 2	Second line of the mailing address for the 'Last/Entity Name' listed.
City	City of the mailing address for the 'Last/Entity Name' listed.
State	A two character designation for the state of the mailing address for the 'Last/Entity Name' listed.
Zip	Five character zip code of the mailing address for the 'Last/Entity Name' listed.
County	A three character code for the county of the mailing address for the 'Last/Entity Name' listed.
Co. Name	The name of the county of the mailing address for the 'Last/Entity Name' listed.
Reason	The reason for suspension or termination given by the MCO. Combines the Reason Code and Reason Code Description. Format: 'Reason Code'<space>'-'<space>'Reason Code Description' List of values for suspension or termination are provided in Exhibit C: Provider Enrollment Activity Reasons.

Report #:	70	Created:	08/21/2011
Name:	Denial of MCO Participation	Last Revised:	09/24/2011

Group:	Provider Enrollment	Report Status:	Active
Frequency:	Monthly	Exhibits:	C
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Report documents any Provider of Subcontractor who is denied participation with the MCO. Only those Providers or Subcontractors who are not currently participating with the MCO are to be reported.

Sample Layout:

Providers or Subcontractors Denied Participation with the MCO												
NPI	Last/Entity Name	First Name	Title	Phone	Addr. 1	Addr. 2	City	State	Zip	County	Co. Name	Reason

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
NA	NA

Column Label	Description
NPI	NPI should be reported as a text string. When the denial applies to a Medical Provider report the Provider's NPI. When the denial is for a subcontractor report 'Subcon'.
Last/Entity Name	6) When the denial applies to an individual Medical Provider report the last name of the Provider. 7) When the denial applies to a Provider group report the group name. 8) When the denial applies to a subcontractor report the last name of the company contact.
First Name	2) When the denial applies to an individual Medical Provider report the first name of the Provider. 9) When the denial applies to a Provider group report the group name. 10) When the denial applies to a subcontractor report the first name of the company contact.
Title	4) When the denial applies to a individual Medical Provider report the title of the Provider. 5) When the denial applies to a Provider Group report 'NA'. 6) When the denial applies to a subcontractor report the title of the company contact.
Phone	Provide the contact number for the 'Last/Entity Name' listed.
Addr. 1	First line of the mailing address for the 'Last/Entity Name' listed.
Addr. 2	Second line of the mailing address for the 'Last/Entity Name' listed.
City	City of the mailing address for the 'Last/Entity Name' listed.
State	A two character designation for the state of the mailing address for the

	'Last/Entity Name' listed.
Zip	Five character zip code of the mailing address for the 'Last/Entity Name' listed.
County	A three character code for the county of the mailing address for the 'Last/Entity Name' listed.
Co. Name	The name of the county of the mailing address for the 'Last/Entity Name' listed.
Reason	The reason for denial given by the MCO. Combines the Reason Code and Reason Code Description. Format: 'Reason Code'<space>'-'<space>'Reason Code Description' List of values for denial are provided in Exhibit C: Provider Enrollment Activity Reasons.

Report #:	71	Created:	09/01/2011
Name:	Provider Outstanding Account Receivables	Last Revised:	09/26/2011
Group:	Finance and Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Provider Outstanding Account Receivables report contains all accounts receivable that have reached 180 days or older in age. If there are no accounts receivable 180 days or older as of the last day of the reporting period then the report is to be submitted with the 'Total' values set to $0.00 and the following comment located at the bottom of the report:

> 'NO ACCOUNTS RECEIVABLE 180 DAYS OR OLDER TO REPORT AS OF THE END OF THE REPORTING PERIOD'

Sample Layout:

Outstanding Account Receivables 180 Days or Older													
AR ID	Provider Tax ID/SSN	Medicaid Provider ID	Provider NPI	Provider Name	AR Setup Date	AR Age	AR Setup Reason	AR Setup Amount	Revised AR Setup Amount	Disposition	AR Balance	Write Off Indicator	TPL Indicator
Total								$0.00	$0.00	$0.00	$0.00		

NO ACCOUNTS RECEIVABLE 180 DAYS OR OLDER TO REPORT AS OF THE END OF THE REPORTING PERIOD

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by provider name.

Row Label	Description
Total	Calculated Field: Total of all reported in each column for 'AR Setup Amount', 'Revised AR Setup Amount', 'Disposition' and 'AR Balance'.

Column Label	Description
AR ID	The MCO identifier for the account receivable.
Provider Tax ID/SSN	Billing Provider Federal Tax ID (FEIN) or SSN of the Billing Provider.
Medicaid Provider ID	The Provider's Medicaid ID
Provider NPI	The Provider's NPI number as reported on the claim.
Provider Name	Concatenate the Provider's 'Last Name', 'First Name' 'Middle Initial'.
AR Setup Date	The date the account receivable was established.
AR Age	The age measured in days of the account receivable as of the last day of the reporting period. The setup date for the account receivable is to be counted.
AR Setup Reason	The reason behind the creation of the account receivable.
AR Setup Amount	The amount originally requested from the provider.
Revised AR Setup Amount	When MCO procedures allow modification of the original account receivable setup amount due to a dispute resolution or write off report the new account receivable setup amount. If the account receivable balance is adjusted rather than the setup amount report the original account receivable setup amount.
Disposition	The total amount applied to the account receivable during the reporting period. Dispositions may include payments received, recoupment or adjustments (dispute resolution or write offs).
AR Balance	The balance of the account receivable as of the last day of the reporting period.
Write Off Indicator	Indicates if the account receivable was partially or completely written off. Valid values are: N = Account receivable not written off. C = Account receivable completely written off. P = Account receivable partially written off.
TPL Indicator	Indicates if the account receivable resulted from identification of TPL. Valid values are 'Y' or 'N'.

Report #:	72	Created:	09/07/2011
Name:	Member Violation Letters and Collections	Last Revised:	09/25/2011
Group:	Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report lists the complaints received and actions taken regarding potential Medicaid program violations by a

Member. The MCO is to open a case for each complaint received and document the related activity for all active/open cases during the reporting period.

A copy of each Medicaid Program Violation (MPV) letter with signature that is mailed during the reporting period is to be provided as an attachment when the Member Violation Letters and Collections report is submitted.

Sample Layout:

Medicaid Program Violation Letters and Collections												
Case Status	Case ID	Member Name	Member Medicaid ID	Member MCO ID	Date Complaint Received	Source of Complaint	Summary of Complaint	Date Case Opened	Actions Taken	Overpayment Amount	Overpayment Collected	Total Overpayment Collected

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted as follows: First sort order by 'Case Status' (N, A, C, I). Second sort order by ascending 'Date Case Opened'.

Row Label	Description
NA	NA

Column Label	Description
Case Status	Identifies if the case is New, Existing or Closed. Valid values are: 1. N = New Case opened during reporting period. 2. A = Active Case and status update 3. C = Closed case with disposition 4. I = Inactive case and status description Only one Case Status is to be reported per line. If a Case is Opened and Closed during the same reporting period then one record with Case Status = N and one record with a Case Status = C will be reported for the case.
Case ID	The Case unique identifier assigned by the MCO.
Member Name	The name of the member the complaint is against. Concatenate the Member's <Last Name>, <First Name> <Middle Initial>.
Member Medicaid ID	The Member's Medicaid ID.
Member MCO ID	The Member's MCO ID.
Date Complaint Received	The date the complaint was received by the MCO.
Source of Complaint	Where the complaint was received from (e.g. hotline).
Summary of Complaint	Short description of the complaint.
Date Case Opened	Date case was opened for review by the MCO. A case shall be opened for all complaints received.
Actions Taken	Activity that occurred after case opened. Valid values are: 1. IO = Investigation Opened 2. ICNA = Investigation closed with no further action with disposition description

	3. MPV = Medicaid Program Violation Letter Sent 4. MPV-NR = Member has not responded to MPV Letter 5. MPV-PS = Member has responded and set up payment schedule/plan 6. MPV-F = Member has paid in full More than one value may be reported per record.
Overpayment Amount	Amount of overpayment identified during the investigation.
Overpayment Collected	Amount of overpayment collected during the reporting period.
Total Overpayment Collected	The total amount of the overpayment collected through the end of the reporting period. Includes previous reporting period collections.

Report #:	73	Created:	09/07/2011
Name:	Explanation of Member Benefits, (EOMB)	Last Revised:	10/17/2011
Group:	Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of the month through the last day of the month		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report identifies the MCO activity in verifying Member benefits for which the MCO received, processed and paid a claim in accordance with 42 CFR 455.20. A minimum of 500 claims is to be sampled for purpose of complying with 42 CFR 455.20. An EOMB is to be mailed within 45 days of payment of claims.

Sample Layout:

Meets 42 CFR 455.20	Member Region	Billing Provider Type	MCO ICN	Date of Contact	Member Name	Member Medicaid ID	Date of Service	Service Code	Service Code Description
Total (Y)									
Total (N)									

Meets 42 CFR 455.20	Member Region	Billing Provider Type	MCO ICN	Payer	Billing Provider Name	Billing Provider Medicaid Number	Rendering Provider Name	Rendering Provider Medicaid Number	Billed Amount	Paid Amount	Response	Action
Total (Y)												
Total (N)												

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by number in column A.

Row Label	Description
Total (Y)	Total (Y) for MCO ICN: Report the unduplicated count of 'MCO ICN' for which the 'Meets 42 CFR 455.20' indicator was set to 'Y'. Total (Y) for Billed Amount: Report the sum of all 'Billed Amount' for which the 'Meets 42 CFR 455.20' indicator was set to 'Y'. Total (Y) for Paid Amount: Report the sum of all 'Paid Amount' for which the 'Meets 42 CFR 455.20' indicator was set to 'Y'. Total (Y) for Collections: Report the sum of all 'Collections' for which the 'Meets 42 CFR 455.20' indicator was set to 'Y'.
Total (N)	Total (N) for MCO ICN: Report the unduplicated count of 'MCO ICN' for which the 'Meets 42 CFR 455.20' indicator was set to 'N'. Total (N) for Billed Amount: Report the sum of all 'Billed Amount' for which the 'Meets 42 CFR 455.20' indicator was set to 'N'. Total (N) for Paid Amount: Report the sum of all 'Paid Amount' for which the 'Meets 42 CFR 455.20' indicator was set to 'N'. Total (N) for Collections: Report the sum of all 'Collections' for which the 'Meets 42 CFR 455.20' indicator was set to 'N'.

Column Label	Description
Meets 42 CFR 455.20	Yes or No indicator to be set as follows: 'Y' is to be used for all letters that were sent in order to meet the federal requirements of 42 CFR 455.20. 'N' is to be used for all letters that were sent for purposes other than compliance with 42 CFR 455.20.
Member Region	The MCO Region where the Member resides. Reported as a two (2) character text string. Valid values are 01, 02, 03, 04, 05, 06, 07 and 08.
Billing Provider Type	Billing Provider Type is designated with a state specific two (2) character field. Example: Billing Provider Type 01 = General Hospital
MCO ICN	The MCO Internal Control Number used to identify the claim. To be reported as a text string.
Date of Contact	The date the MCO imitated the action. Letter = Date of the Letter
Contact Type	The type of communication the MCO used to contact the Member. Valid Codes are: L = Letter
Member Name	The name of the member that received the EOB letter.
Member Medicaid ID	The Medicaid ID of the Member contacted. To be reported as a text string.
Date of Service	Date of Service of claim
Service Code	The code (e.g. procedure code, revenue code) for the service that was rendered to the member.
Service Code Description	The description of the 'Service Code' for the service that was rendered to

	the member.
Payer	The name of the payer source. If the MCO paid the claim report MCO. If an MCO subcontractor paid the claim then list the service description of the Subcontractor (i.e. Pharmacy, Dental, Vision, PCP Cap)
Billing Provider Name	The name of the provider who has billed for service rendered.
Billing Provider Medicaid Number	The Medicaid ID number for the provider who has billed for service rendered.
Rendering Provider Name	The name of the provider who rendered the service to the member for that specific date of service.
Rendering Provider Medicaid Number	The Medicaid ID number for the provider who has rendered the service to the member.
Billed Amount	Total billed amount for the 'Service Code'.
Paid Amount	Total paid amount by the MCO or the MCO subcontractor for the 'Service code'.
Response	If the Member has not responded then report 'No Member Response'. If the Member responded then concatenate the following: <date of response>,<->,<validation code>. Validation codes are: RB = Received Benefit NB = No Benefit Received PB = Partial Benefit Received

Billing Provider Type Codes	Paid Amount	Savings YTD	Monthly Admits	Average Savings YTD

Action	The Action the MCO took based on the Member's response. Multiple actions may be reported. Valid Actions are: NAT: No Action Taken IPI: Initiated Provider Investigation RPA: Requested Provider Billing Adjustment ARS: Accounts Receivable Setup to Recoup Payment

Report #:	74(A)	Created:	10/19/2011
Name:	Medicaid Program Lock-In Reports/Admits Savings Summary Table	Last Revised:	10/19/2011
Group:	Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report lists the monthly savings for the total number of members admitted during the month and sub-categorized by the billing provider type codes.

Sample Layout:

	1 Year Pre Lock-In	1 Month Post Lock-In			
Totals					

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Row Label	**Description**
Provider Type Codes	Provider type codes
Totals	The total sum of combined provider type codes in dollar amount

Column Label	Description
Billing Provider Type Codes	Listed are the different provider type codes to be utilized for this report.
Paid Amount	The paid amount is divided into two categories; (1) 1 Year Pre-LIP is the total paid amount for each provider type listed in the first column (Billing provider type codes) for the total number of members admitted one year prior to being assigned to the Lock-In Program ; (2) Is the monthly running YTD (year to date)of paid amounts for each provider type listed in the first column for the member after being assigned into the Lock-In Program for the first year from the MCO taking over the LIP. After the first 12 months, the second category will report the 1st year post – LIP for each report month and yearly thereafter.(Example: column (2) will initially read 1 month post LI, then the next month it will read 2 month post …through the first 12 months. After the first year, the second category will always list **1 year Post-LIP** for the month the report is generated.
Savings YTD	The total savings YTD for each provider type for the reporting period.
Monthly Admits	The total number of members that were placed into the Lock-In Program for the monthly reporting period.
Average Saving YTD	The average saving YTD (year to date) per member per month per provider type.(Savings YTD : Monthly admits = average savings YTD)

Report #:	74(B)	Created:	10/19/2011
Name:	Medicaid Program Lock-In Reports/Rolling Annual Calendar Comparison	Last Revised:	10/19/2011

Group:	Program Integrity	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report lists the total savings created by the Lock-In Program reported on a quarterly basis.

Sample Layout:

Billing Provider Type Codes	Savings for 2011 YTD				Total savings 2011 YTD	Savings for 2012 YTD				Total Savings 2011 and 2012 YTD	Notes/ Comments
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter		
TOTALS:											

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Row Label	**Description**
Billing Provider Type Codes	Billing Provider type codes
Totals	The total sum of combined billing provider type codes in dollar amount

Column Label	Description
Billing Provider Type Codes	Billing Provider type codes
Savings for YTD (2011)	Savings for year to date totals
1st, 2nd, 3rd, and 4th quarters for year reported (2011)	The total savings for each provider type listed per calendar quarter of year reported.
Total Savings 2011 YTD	The sum of the total savings for each provider type listed of year reported
Savings for YTD (2012)	Savings for year to date totals per quarter
1st, 2nd, 3rd, and 4th quarters for year reported (2012)	The total savings for each provider type listed per calendar quarter of year reported.
Total Savings 2012 YTD	The sum of the total savings for each provider type listed of year reported
Notes/Comments	Additional Notes/Comments

Report #:	74(C)	Created:	10/19/2011

Name:	Medicaid Program Lock-In Reports/Member Initial Lock-In Effective Dates	Last Revised:	10/19/2011
Group:	Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report lists the total number of members that have been admitted and discharged into the Lock-In Program for the month reported. The report also lists the total number of currently active member assigned to the Lock-In Program.

Sample Layout:

Monthly	Number of Members **Admitted** per Month	Number of Members **Discharged** per Month	Total Number of Members **Active** in LIP per Month	Notes/Comments
TOTAL YTD				

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Row Label	**Description**
Year	The year listed for the reporting period.
Month	The individual month listed for the year for the reporting period.

Column Label	Description
Monthly Data	List the individual month for each reporting year.
Member	Member count of admitted/discharged/active members.
Number of Members **Admitted** per Month	The total number of members that have been admitted into the Lock-In Program during the monthly reporting period.
Number of Members **Discharged** per Month	The total number of members that have been discharged from the Lock-In Program during the monthly reporting period.
Total Number of Members **Active** in LIP per Month	The total number of members that are active or currently assigned to the Lock-In Program during the monthly reporting period.
Notes/Comments	Additional notes/comments

Report #:	75	Created:	09/01/2011
Name:	SUR Algorithms	Last Revised:	09/22/2011
Group:	Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The SUR Algorithm report identifies potential overpayments to providers determined to be erroneous, abusive or otherwise inconsistent with DMS and/or MCO policy. The report is to include only those providers for which a demand letter was sent.

MCO algorithms that are routinely run are to be identified, documented and provided to DMS prior to the first submission of the SUR Algorithms Report. If the MCO modifies and/or creates specially designed algorithms that are used in reporting any subsequent SUR Algorithm report, the MCO is to provide DMS at the time of report submission documentation related to the algorithm including the algorithm name, algorithm description and algorithm logic.

Sample Layout:

Program Integrity - SUR - Algorithms											
Medicaid Provider ID	Provider Name	Tax ID/SSN	Provider Type	Algorithm Name	Demand LTR Date	Review Period	Identified Overpayment	Disputed	Revised Overpayment	Collected Overpayment	Total Overpayment Collected
				sub-total for <Algorithm Name>:			$0.00	0	$0.00	$0.00	$0.00
				sub-total for <Algorithm Name>:			$0.00	0	$0.00	$0.00	$0.00
				sub-total for <Algorithm Name>:			$0.00	0	$0.00	$0.00	$0.00
				Total for all Algorithms:			$0.00	0	$0.00	$0.00	$0.00

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by ‘Algorithm Name’ by ’Demand LTR Date’ by ‘Medicaid Provider ID’.

Row Label	Description
Sub-total for <Algorithm Name>:	A sub-total for the ‘Identified Overpayment’, ‘Revised Overpayment’, ‘Collected Overpayment’ and ‘Total Overpayment Collected’ columns for each ‘Algorithm Name’ is to be calculated for all reported activity.

	A sub-total of all <Y> listed in the 'Disputed' column is to be calculated for all reported activity.
Total for all Algorithms:	A total of all algorithm sub-totals is to be calculated for the 'Identified Overpayment', 'Revised Overpayment', 'Collected Overpayment' and 'Total Overpayment Collected' columns for all reported activity. A total of all algorithm sub-totals is to be calculated for the 'Disputed' column for all reported activity.

Column Label	Description
Medicaid Provider ID	The Provider's Medicaid ID
Provider Name	Concatenate the Providers <Last Name>, <First Name> ,Middle Initial>
Tax ID/SSN	The Provider's FEIN number or SSN
Provider Type	Concatenate <Billing Provider Type> - <Billing Provider Type Description>. Values for Provider Type are provided in Exhibit A: Billing Provider Type and Specialty Crosswalk .
Algorithm Name	The name and/or title designated to a specific algorithm.
Demand LTR Date	The letter and mailing date of the demand letter pertaining to a specific algorithm and Provider.
Review Period	The time span (dates-of-service) of claims reviewed for a specific algorithm.
Identified Overpayment	A potential overpayment amount identified through an algorithm as reported on the demand letter.
Disputed	Valid codes are: Y = Demand Letter was Disputed N= Demand Letter was not Disputed
Revised Overpayment	If the Demand Letter was disputed and the overpayment amount was changed then report the new overpayment amount. Otherwise report the overpayment amount as identified in the Demand Letter.
Collected Overpayment	The amount collected during the reporting period based on a specific algorithm demand letter.
Total Overpayment Collected	The total amount collected since the demand letter was sent through the end of the reporting period.

Report #:	76	Created:	09/01/2011
Name:	Provider Fraud Waste and Abuse Report	Last Revised:	10/12/2011
Group:	Program Integrity	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Provider Fraud Waste and Abuse report should contain all cases acted upon during the reporting period. New cases, action taken on existing cases, and closed cases are to be identified and the outcome of the investigation documented.

Sample Layout:

Provider Fraud Waste and Abuse										
Case Number	Provider Name	Medicaid Provider ID	Provider NPI	Date Complaint Received	Source of Complaint	Date Case Opened	Summary of Complaint	Actions Taken	Overpayment Identified	Date Case Closed

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'Medicaid Provider ID'

Row Label	Description
NA	NA

Column Label	Description
Case Number	The unique number assigned by the MCO to identify the case.
Provider Name	The specific name of the provider (individual, group or clinic) that the complaint was filed against.
Medicaid Provider ID	Report the Medicaid Provider ID if an individual provider. Report the Medicaid Billing Provider ID if a Facility or group practice. ID is to be reported as a text string.
Provider NPI	The Provider's NPI number reported as a text string.
Date Complaint Received	The date the complaint was received by the MCO.
Source of Complaint	Where the complaint was received from (e.g. hotline).
Date Case Opened	Date the case was opened for review by the MCO.
Summary of Complaint	Short description of the complaint.
Actions Taken	Valid codes to be reported are listed below. All codes related to the case are to be reported regardless if the action was taken during the reporting period. Multiple codes are to be reported in the ascending date/time order the action was taken and separated by a comma. Code — Code Description IO — Investigation Opened ICNA — Investigation Closed (no Action) AC — Administrative Action Taken by MCO (no Fraud) OIG — Referral to OIG for Preliminary Investigation OLE — Referral to Other Law Enforcement Agencies (e.g. Local Law Enforcement, US Atty., DEA etc.) KASP — KASPER Report Requested for Review MFCU — Referral to OAG/MFCU for Full Investigation CI — Collection Initiated

Overpayment Identified	Amount identified during the investigation that may have resulted from fraud, waste and/or abuse.
Date Case Closed	The date the case was closed.

Report #:	77	Created:	10/02/2011
Name:	Member Fraud Waste and Abuse	Last Revised:	10/12/2011
Group:	Program Integrity	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Member Fraud Waste and Abuse report should contain all cases acted upon during the reporting period. New cases, action taken on existing cases, and closed cases are to be identified and the outcome of the investigation documented.

Sample Layout:

Member Fraud Waste and Abuse									
Case Number	Medicaid Member ID	Member Name	Date Complaint Received	Source of Complaint	Date Case Opened	Summary of Complaint	Actions Taken	Overpayment Identified	Date Case Closed

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'Medicaid Member ID'

Row Label	Description
NA	NA

Column Label	Description
Case Number	The unique number assigned by the MCO to identify the case.
Medicaid Member ID	Member's Medicaid ID reported as a text string.
Member Name	The name of the Medicaid member. Concatenate the Member's <Last Name>, <First Name> <Middle Initial>
Date Complaint Received	The date the complaint was received by the MCO.
Source of Complaint	Where the complaint was received from (e.g. hotline).
Date Case Opened	Date the case was opened for review by the MCO.
Summary of Complaint	Short description of the complaint.
Actions Taken	Valid codes to be reported are listed below. All codes related to the case

	are to be reported regardless if the action was taken during the reporting period. Multiple codes are to be reported in the ascending date/time order the action was taken and separated by a comma. Code — Code Description IO — Investigation Opened ICNA — Investigation Closed (no Action) AC — Administrative Action Taken by MCO (no Fraud) OIG — Referral to OIG for Preliminary Investigation OLE — Referral to Other Law Enforcement Agencies (e.g. Local Law Enforcement, US Atty., DEA etc.) KASP — KASPER Report Requested for Review CI — Collection Initiated LI — Member Placed in Lock-in Program
Overpayment Identified	Amount identified during the investigation that may have resulted from fraud, waste and/or abuse.
Date Case Closed	The date the case was closed.

Report #:	78	Created:	08/23/2011
Name:	Quarterly Benefit Payments	Last Revised:	08/28/2012
Group:	Financial	Report Status:	Active
Frequency:	Quarterly	Exhibits:	D, E, F
Period:	First day of quarter through the last day of quarter.		
Due Date:	15 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Quarterly Benefit Payments report provides MCO financial activity for the Medicaid and Kentucky Children's Health Insurance Program (KCHIP) by MCO Region, Month and State Category of Service. Report only includes financial activity related to Benefits including claims, claim adjustments, mass adjustments, sub-capitation, and other financial payments/recoupment activity not processed as part of claims activity. Categories of Service are grouped by Medicaid Mandatory and Medicaid Optional Services. Criteria to properly identify and report EPSDT services and KCHIP services are to be applied as outlined below.

Sample Layout:

		MCO Data for LRC Quarterly Report			
		Medicaid (non KCHIP) - Region 01			
COS	COS Description	mm/yyyy	mm/yyyy	mm/yyyy	Qrt Total
Medicaid Mandatory Services					
02	Inpatient Hospital				$0.00

12	Outpatient Hospital				$0.00
	Subtotal: Mandatory Services	$0.00	$0.00	$0.00	$0.00

Medicaid Optional Services

03	Mental Hospital				$0.00
04	Renal Dialysis Clinic				$0.00
	Subtotal: Optional Services	$0.00	$0.00	$0.00	$0.00

Total: Mandatory and Optional Services	$0.00	$0.00	$0.00	$0.00

Reinsurance				$0.00
Pharmacy Rebates				$0.00

Grand Total	$0.00	$0.00	$0.00	$0.00

		MCO Data for LRC Quarterly Report			
		KCHIP - Region 01			
COS	COS Description	mm/yyyy	mm/yyyy	mm/yyyy	Qrt Total

Medicaid Mandatory Services

02	Inpatient Hospital				$0.00
12	Outpatient Hospital				$0.00
	Subtotal: Mandatory Services	$0.00	$0.00	$0.00	$0.00

Medicaid Optional Services

03	Mental Hospital				$0.00
04	Renal Dialysis Clinic				$0.00
	Subtotal: Optional Services	$0.00	$0.00	$0.00	$0.00

Total: Mandatory and Optional Services	$0.00	$0.00	$0.00	$0.00

Reinsurance				$0.00
Pharmacy Rebates				$0.00

Grand Total	$0.00	$0.00	$0.00	$0.00

Reporting Criteria:

General Specifications	Definition
Financial Activity	Payments reported are to be based on date of payment.
EPSDT Services	Multiple Provider Types may provide EPSDT services. Reference Exhibit E for EPSDT Category of Service crosswalk for additional information regarding the identification of EPSDT services.
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Subtotal: Mandatory Services	Calculated Field: Total for all mandatory category of services listed in the report.
Subtotal: Optional Services	Calculated Field: Total for all optional category of services listed in the report.
Total: Mandatory and Optional Services	Calculated Field: Total of 'Subtotal: Mandatory Services' and 'Subtotal: Optional Services'.
Reinsurance	MCO premium payments for stop-loss insurance coverage.
Pharmacy Rebates	Drug Rebates collected by the MCO. 'Pharmacy Rebates' is to be reported as a negative value. Note: The state is responsible for collecting federal drug rebates.
Grand Total	Calculated Field: Total of 'Total: Mandatory and Optional Services', 'Reinsurance' and 'Pharmacy Rebates'.

Column Label	Description
COS	Category of Service: State specific identification of services primarily identified by use of Provider Type. Reference Exhibit D for Category of Service crosswalk.
COS Description	Description for 'COS'
Medicaid (non-KCHIP)	The Medicaid population services are to be reported separately from the KCHIP population services. Populations to be included are based on the Medicaid Eligibility Groups (MEGs): 1. Dual Medicare and Medicaid 2. SSI Adults, SSI Children and Foster Care 3. Children 18 and Under 4. Adults Over 18 Reference Exhibit F for the Medicaid Eligibility Group crosswalk.
KCHIP	The Kentucky Children's Health Insurance Program (KCHIP) population services are to be reported separately from the Medicaid population services. Populations to be included are based on the Medicaid Eligibility Groups (MEGs): 1. MCHIP 2. SCHIP Reference Exhibit F for the Medicaid Eligibility Group crosswalk.
Region	Reporting of MCO Enrollee benefit payments is to be based on the Enrollee's region.

Report #:	79	Created:	01/09/2012
Name:	Health Risk Assessments	Last Revised:	03/02/2012
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO shall conduct initial Health Risk Assessments (HRAs) of new Members who have not been enrolled in the prior twelve (12) month period for the purpose, of accessing the Members need for any special health care needs within ninety (90) days of Enrollment. Enrollment period for new members begins when the MCO receives the member on an HIPAA 834 (MCO receives an HIPAA 834 on January 15, 2012 with retro eligibility December 01, 2011. The 30 or 90 day clock would start on January 15th versus the retro eligibility date. HRAs should be reported and broken out by Region.

Sample Layout:

New HRAs Initiated (Total)	New HRAs Initiated (Pregnant)	% non Pregnant Completed within 90 Days of Enrollment	% Pregnant Completed within 30 Days of Enrollment	HRAs in Process	HRAs not Completed after Reasonable Effort	Members Refusing to Participate	Number of Members Enrolled in Case Management	Number of Members Enrolled in Disease Management
0	0	0.0%	0.0%	0	0	0	0	0

Reporting Criteria:

Row Label	Definition
Region	Provide HRA data by each region.

Column Label	Description
Number of HRAs Initiated (Total)	Provide the total number of HRAs initiated during the month.
Number of HRAs Initiated Pregnant (Total)	Provide the total number of HRAs initiated for pregnant women during the month.
% non Pregnant Completed within 90 Days of Enrollment	Provide the percentage of the non pregnant completed within 90 days of enrollment.
% Pregnant Completed within 30 days of Enrollment	Provide the percentage of pregnant completed within 30 days of enrollment.
HRAs in Process	Provide the number HRA's in process during the month.
HRAs not Completed after Reasonable	Provide the number of HRAs not completed after reasonable effort.

Effort	
Members Refusing to Participate	Provide the number of members refusing to participate.
Number of Members Enrolled in Case Management	Provider the number of members enrolled in case management during the report period.
Number of Members Enrolled in Disease Management	Provide the number of members enrolled in disease management during the report period.

Report #:	80	Created:	01/23/2012
Name:	Provider Changes in Network	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should report the number of Primary Care Providers (PCP) in network accepting new members, not accepting new members and panel size.

Sample Layout:

PCP Physician or Office Name	Accepting New Members (Y/N)	Not Accepting New Members (Y/N)	Beginning Panel Size	Ending Panel Size	Percentage of Change During Quarter
Total	0	0	0	0	0.0%

Reporting Criteria:

Row Label	Description
NA	NA

Column Label	Description
PCP Physician or Office Name	Provide the PCP Physician or Office Name.
Accepting New Members (Y/N)	Provide a Yes or No if the Provider is accepting new members.

Not Accepting New Members (Y/N)	Provide a Yes or No if the provider is not accepting new members.
Beginning Panel Size	Provide the beginning number of members assigned to the PCP during the report period.
Ending Panel Size	Provider the ending number of member assigned to the PCP during the report period.
% of Change During the Quarter	Provide the percentage of change of the beginning versus the ending panel sizes during the report period.

Report #:	81	Created:	01/23/2012
Name:	Par and Non-Par Provider Participation	Last Revised:	02/02/2012
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should provide the number of claims, billed and paid amounts for participating providers versus the number of claims, billed and paid amounts for non-participating providers.

Sample Layout:

Participating Providers Number of Claims	Participating Providers Billed Amount	Participating Providers Paid Amount	Non-Participating Providers Number of Claims	Non-Participating Providers Billed Amount	Non-Participating Providers Paid Amount
0	0	0	0	0	0

Reporting Criteria:

Row Label	Description
NA	NA

Column Label	Description
Participating Providers Number of	Provide the number of participating provider claims.

Claims	
Participating Providers Billed Amount	Provide the billed dollar amount of participating claims.
Participating Providers Paid Amount	Provide the paid dollar amount of participating claims.
Non-Participating Providers Number of Claims	Provide the number of non-participating provider claims.
Non-Participating Providers Billed Amount	Provide the billed dollar amount of non-participating claims.
Non-Participating Providers Paid Amount	Provide the paid dollar amount of non-participating claims.

Report #:	84	Created:	12/12/2011
Name:	Quality Assessment and Performance Improvement Project	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	Ongoing		
Due Date:	July 31st		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO's Quality Assessment and Performance Improvement (QAPI) Program shall conform to requirements of 42 CFR 438, Subpart D at a minimum. The MCO shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members. Behavioral Health services, the Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, on-going process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members. The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the MCO. The Contractor's QI structures and processes shall be planned, systematic and clearly defined. Annually, the MCO shall submit the QAPI program description document to the Department for review by July 31 of each contract year.

Report #:	85	Created:	12/12/2011
Name:	Quality Improvement Plan and Evaluation	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	Ongoing		
Due Date:	July 31st		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO's Quality Assessment and Performance Improvement (QAPI) Program shall monitor and evaluate the quality of health care on an ongoing basis and conform to requirements of 42 CFR 438, Subpart D at a minimum. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines. Standardized quality indicators shall be used to assess improvement, assure achievement of at least minimum performance levels, monitor

adherence to guidelines and identify patterns of over- and under-utilization. The measurement of quality indicators selected by the Contractor must be supported by valid data collection and analysis methods and shall be used to improve clinical care and services.

Annually, the MCO shall submit the Quality Improvement Plan and Evaluation document to the Department for review by July 31 of each contract year.

Report #:	86	Created:	01/09/2012
Name:	Annual Outreach Plan	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	Ongoing		
Due Date:	July 31st		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO shall develop, administer, implement, monitor and evaluate a Member and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to all Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.

Educational and outreach efforts shall be carried on throughout the Contractor's Region. Creative methods will be used to reach Members and community partners. These will include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites.

The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.

Annually, the MCO shall submit the Annual Outreach Plan document to the Department for review by July 31 of each contract year.

Sample Layout:

Quality Improvement Activity	MCO Responsible Staff Person/People	Monitoring Frequency	Quarterly Activity Summary
Activity Name: Objective: Goal: Monitoring:			1st Quarter 20XX: 2nd Quarter 20XX: 3rd Quarter 20XX: 4th Quarter 20XX:
Activity Name: Objective: Goal: Monitoring:			1st Quarter 20XX: 2nd Quarter 20XX: 3rd Quarter 20XX: 4th Quarter 20XX:

Activity Name: Objective: Goal: Monitoring:			1st Quarter 20XX: 2nd Quarter 20XX: 3rd Quarter 20XX: 4th Quarter 20XX:

Reporting Criteria:

Row Label	Description
Activity Name	Provide the name of the QAPI Activity.
Objective	Provide the objective of the QAPI Activity.
Goal	Provide evaluation and track events and quality of care concerns.
Monitoring	Provide MCO staff person or committee responsible for monitoring.

Column Label	Description
Quality Improvement Activity	Provide the QAPI Activity along with objective, goal and monitoring for each activity.
MCO Staff Responsible Person or People	Provide the MCO staff person/people responsible for the QAPI activity.
Monitoring Frequency	Provide the monitoring frequency of each QAPI activity.
Quarterly Activity Summary	Provide the quarterly summaries of each QAPI activity.

Report #:	90	Created:	10/29/2011
Name:	Performance Improvement Projects Proposal	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	N/A
Period:			
Due Date:	01-SEP		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Performance Improvement Projects Proposal report provides the clinical or non-clinical focus areas for the annual performance improvement projects. The report is to be submitted based on the layout provided in the Health Plan Performance Improvement Project (PIP) document. The sections from the Health Plan Performance Improvement Project (PIP) document that are to be completed for submission of the Performance Improvement Projects Proposal report are:

- Cover Page;
- MCO and Project Identifiers;
- MCO Attestation;
- Project Topic;
- Methodology; and
- Interventions.

Report #:	91	Created:	08/20/2011
Name:	Abortion Procedures	Last Revised:	08/29/2011
Group:	Financial	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of quarter.		
Due Date:	15 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Claim listing of abortion procedures paid by the MCO within a quarter. In the event that no procedures were paid for during the reporting period, the report is still required to be provided. Attachments to be provided with the report include:

1. Claim Form
2. Pre-op and/or Post-op Notes
3. Physician Certificate
4. Remittance Advice

The Department for Medicaid Services keeps all originals and provides CMS a copy of the Abortion Procedures Report, along with copies of all attachments stamped CONFIDENTIAL with confidential information redacted (except the last four numbers of the SS# as required by CMS).

Sample Layout:

Abortion Procedures							
MCO Region	Member ID	Member DOB	Provider NPI	Claim ICN	First DOS	Last DOS	Paid Amount

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'MCO Region' by 'Member ID' by 'First DOS'.

Row Label	Description
Sub-total	Although not shown on the report template, a subtotal line is to be added after each Region. Sub-total figures are to be reported for Medicaid ID, Claim ICN and Paid Amount columns. Definition for each calculation is the same as listed for the 'Total' but limited to the Region.
Total	1. Medicaid ID: Total unduplicated Member IDs for the reporting period. 2. Claim ICN: Total count of all claim ICNs for the reporting period. 3. Paid Amount: Total payments for all procedures for the reporting period

Column Label	Description
MCO Region	The MCO Region is determined by the Member's county at the time the service was provided. The MCO shall be under contract to provide Medicaid services in the Region reported. Valid region codes are 01, 02, 03, 04, 05, 06, 07, and 08.
Member ID	The Member's Medicaid ID.
Member DOB	The Member's date of birth.
Provider NPI	The Provider's NPI number as reported on the claim.
Claim ICN	The MCO claim internal control number for the claim being reported.
First DOS	First date of service as reported on the claim.
Last DOS	Last date of service as reported on the claim.
Paid Amount	The total adjudicated claim paid amount by the MCO. Example: A claim adjudicated to pay $100. There is an outstanding A/R in financial for $200. The MCO should report the $100 adjudicated paid amount and not the $0 financial payment.

Report #:	92	Created:	10/29/2011
Name:	Performance Improvement Projects Measurement	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	N/A
Period:			
Due Date:	01-SEP		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Performance Improvement Projects Measurement report provides the baseline, interim, and final results of the Performance Improvement Projects.

The baseline report is to be submitted in the format as outlined in the Health Plan Performance Improvement Project (PIP) document.

The interim report is to be submitted in the format as outlined in the Health Plan Performance Improvement Project (PIP) document.

The final report is to be submitted in the format as outlined in the Health Plan Performance Improvement Project (PIP) document.

A Project Review Guidelines is provided as a separate document which outlines how the PIPs will be evaluated and also provides guidance to the plans on what is expected through the PIP lifetime. The actual scoring of a PIP may differ based on the EQRO contracted with the Department.

Report #:	93	Created:	11/08/2011
Name:	EPSDT CMS-416	Last Revised:	
Group:		Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	Federal Fiscal Year: 01-OCT through 30-SEP		
Due Date:	15-MAR		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The EPSDT CMS-416 report is required annually. The specifications for the EPSDT CMS-416 report shall be in compliance with the most current CMS-416: Annual EPSDT Participation Report and shall be based on Federal Fiscal Year (FFY).

Report #:	94	Created:	11/08/2011
Name:	Member Surveys	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	Calendar Year: 01-JAN through 31-DEC		
Due Date:	31-AUG		
Submit To:	Kentucky Department for Medicaid Services		

Description:

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

Report #:	95	Created:	11/08/2011
Name:	Provider Surveys	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	NA

Period:	Calendar Year: 01-JAN through 31-DEC		
Due Date:	31-AUG		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The Contractor shall conduct an annual survey of Providers' satisfaction. To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's provider satisfaction survey tool. The Department shall review and approve any Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used conducting the Provider or other special surveys, the number and percentage of the Providers to be surveyed, response rates, and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.

Report #:	96	Created:	11/08/2011
Name:	Audited HEDIS Reports	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	Calendar Year: 01-JAN through 31-DEC		
Due Date:	31-AUG		
Submit To:	National Committee for Quality Assurance (NCQA) Kentucky Department for Medicaid Services		

Description:

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

In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.

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

Report #:	97	Created:	10/08/2011
Name:	Behavioral Health Adults and Children	Last Revised:	10/15/2011
Group:	Mental Health and Substance Abuse	Report Status:	Active

Frequency:	Monthly	Exhibits:	A, G, H
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:

The report identifies the utilization of Behavioral Health Services provided to children and adults. All claims activity paid or denied during the reporting period is to be reported. All provider types billing for mental health and substance abuse services are to be reported.

Sample Layout:

Utilization of Behavioral Health Services by Adults and Children															
Provider ID	MCO Region		Provider Type	MH/SA Procedure Code	Procedure Code Modifier	Date Of Service		Behavioral Health Population	Child/Adult	Units	Users	Provider Billed Amount	MCO Paid Amount	Denied Count	Denied Billed Amount
	Provider	Member				Month	Year								

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in order: MCO Region: Provider (ascending), Provider ID (ascending), MH/SA Procedure Code (ascending) and Procedure Code Modifier (ascending).

Row Label	Description
NA	NA

Column Label	Description
Provider ID	The Provider's Medicaid ID.
MCO Region: Provider	The Medical Region of the Provider location where the service was rendered. Report as a two character field. Valid values for services provided in Kentucky are 01 through 08. Services provided out of state are to be reported as 09.
MCO Region: Member	The Medical Region of the Member's residence. Report as a two character field. Valid values are 01 through 08.
Provider Type	All Provider Types billing for MH/SA procedure codes are to be listed. Billing Provider Type is designated with a state specific two (2) character field. Crosswalk of Provider Type and Provider Specialty to each Provider Description is provided in Exhibit A: Provider Type and Specialty Crosswalk.
MH/SA Procedure Code	The Mental Health/Substance Abuse (MH/SA) procedure code submitted by the billing provider for reimbursement. A listing of MH/SA Procedure

	Codes is provided in Exhibit H: MH/SA Procedure Codes. The MH/SA procedure code list is provided as a guide and may change based on industry practices.
Procedure Code Modifier	The modifier submitted with the procedure code on the claim.
Date of Service: Month	A two character designation for the month the service was provided. Valid values are 01 through 12.
Date of Service: Year	A four character designation for the year the service was provided.
Behavioral Health Population	A code value to designate the population for which the MH/SA service was provided. Populations are defined in Exhibit G: Behavioral Health Populations. Valid values are: GEN: General Mental Health Population SMI: Serious Mental Illness Population SED: Serious Emotional Disability Population
Child/Adult	A code value to designate the population. The Member's age is determined based on the first date of service for the procedure as reported on the claim. Valid values are: A = Adults age 18 and over. C = Children age 17 and under.
Units	The total number of allowed units of service paid for by the MCO or the MCO subcontractor during the month that is reported.
Users	The total number of unduplicated Members for which an allowable service was paid for by the MCO or the MCO subcontractor during the month that is reported.
Provider Billed Amount	Total of billed charges for allowable units as reported on the claim.
MCO Paid Amount	Total amount paid by the MCO or the MCO subcontractor for allowable units during the month that is reported.
Denied Count	The number of claim line item details denied by the MCO or the MCO subcontractor during the month that is reported.
Denied Billed Amount	Total of billed charges for the claim line item details denied by the MCO or the MCO subcontractor during the month that is reported.

Report #:	98	Created:	10/13/2011
Name:	Behavioral Health Pregnant and Postpartum	Last Revised:	10/15/2011
Group:	Mental Health and Substance Abuse	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, G, H
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:

The report identifies the utilization of Behavioral Health Services provided to pregnant and postpartum Members. The postpartum period covers sixty (60) days after the date of delivery. All claims activity paid or denied during the reporting period is to be reported. All provider types billing for mental health and substance abuse services are to be reported.

Sample Layout:

Utilization of Behavioral Health Services by Pregnant and Postpartum Members																
Provider ID	MCO Region		Provider Type	MH/SA Procedure Code	Procedure Code Modifier	Date Of Service		Behavioral Health Population	Child/Adult	Pregnant/ Postpartum	Units	Users	Provider Billed Amount	MCO Paid Amount	Denied Count	Denied Billed Amount
	Provider	Member				Month	Year									

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in order: MCO Region: Provider (ascending), Provider ID (ascending), MH/SA Procedure Code (ascending) and Procedure Code Modifier (ascending).

Row Label	Description
NA	NA

Column Label	Description
Provider ID	The Provider's Medicaid ID.
MCO Region: Provider	The Medical Region of the Provider location where the service was rendered. Report as a two character field. Valid values for services provided in Kentucky are 01 through 08. Services provided out of state are to be reported as 09.
MCO Region: Member	The Medical Region of the Member's residence. Report as a two character field. Valid values are 01 through 08.
Provider Type	All Provider Types billing for MH/SA procedure codes are to be listed. Billing Provider Type is designated with a state specific two (2) character field. Crosswalk of Provider Type and Provider Specialty to each Provider Description is provided in Exhibit A: Provider Type and Specialty Crosswalk.
MH/SA Procedure Code	The Mental Health/Substance Abuse (MH/SA) procedure code submitted by the billing provider for reimbursement. A listing of MH/SA Procedure Codes is provided in Exhibit H: MH/SA Procedure Codes. The MH/SA procedure code list is provided as a guide and may change based on industry practices.
Procedure Code Modifier	The modifier submitted with the procedure code on the claim.
Date of Service: Month	A two character designation for the month the service was provided. Valid values are 01 through 12.
Date of Service: Year	A four character designation for the year the service was provided.
Behavioral Health Population	A code value to designate the population for which the MH/SA service was provided. Populations are defined in Exhibit G: Behavioral Health Populations. Valid values are: GEN: General Mental Health Population SMI: Serious Mental Illness Population

	SED: Serious Emotional Disability Population
Child/Adult	A code value to designate the population. The Member's age is determined based on the first date of service for the procedure as reported on the claim. Valid values are: A = Adults age 18 and over. C = Children age 17 and under.
Pregnant/Postpartum	A code value to designate the population. Valid values are: PREG = Pregnant. POST = Postpartum.
Units	The total number of allowed units of service paid for by the MCO or the MCO subcontractor during the month that is reported.
Users	The total number of unduplicated Members for which an allowable service was paid for by the MCO or the MCO subcontractor during the month that is reported.
Provider Billed Amount	Total of billed charges for allowable units as reported on the claim.
MCO Paid Amount	Total amount paid by the MCO or the MCO subcontractor for allowable units during the month that is reported.
Denied Count	The number of claim line item details denied by the MCO or the MCO subcontractor during the month that is reported.
Denied Billed Amount	Total of billed charges for the claim line item details denied by the MCO or the MCO subcontractor during the month that is reported.

Report #:	100	Created:	10/13/2011
Name:	EPSDT for Behavioral Health Populations	Last Revised:	10/15/2011
Group:	Mental Health and Substance Abuse	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, D, E, H
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:

The report identifies the utilization of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services by the Behavioral Health populations. All claims activity paid or denied during the reporting period is to be reported. All provider types billing for mental health and substance abuse services are to be reported.

Sample Layout:

Utilization of EPSDT Services by the Behavioral Health Populations															
Provider ID	MCO Region		Provider Type	EPSDT Procedure Code	Procedure Code Modifier	Date Of Service		Behavioral Health Population	Child/Adult	Units	Users	Provider Billed Amount	MCO Paid Amount	Denied Count	Denied Billed Amount
	Provider	Member				Month	Year								

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in order: MCO Region: Provider (ascending), Provider ID (ascending), MH/SA Procedure Code (ascending) and Procedure Code Modifier (ascending).

Row Label	Description
NA	NA

Column Label	Description
Provider ID	The Provider's Medicaid ID.
MCO Region: Provider	The Medical Region of the Provider location where the service was rendered. Report as a two character field. Valid values for services provided in Kentucky are 01 through 08. Services provided out of state are to be reported as 09.
MCO Region: Member	The Medical Region of the Member's residence. Report as a two character field. Valid values are 01 through 08.
Provider Type	All Provider Types billing for EPSDT services are to be listed. Billing Provider Type is designated with a state specific two (2) character field. Crosswalk of Provider Type and Provider Specialty to each Provider Description is provided in Exhibit A: Provider Type and Specialty Crosswalk. Additional information regarding EPSDT services may be found in Exhibit D: Category of Service Crosswalk and Exhibit E: EPSDT Category of Service Crosswalk.
EPSDT Procedure Code	All EPSDT services provided to the Behavioral Health population are to be reported. Additional information regarding EPSDT services may be found in Exhibit D: Category of Service Crosswalk and Exhibit E: EPSDT Category of Service Crosswalk.
Procedure Code Modifier	The modifier submitted with the procedure code on the claim.
Date of Service: Month	A two character designation for the month the service was provided. Valid values are 01 through 12.
Date of Service: Year	A four character designation for the year the service was provided.
Behavioral Health Population	A code value to designate the population for which the EPSDT service was provided. Populations are defined in Exhibit G: Behavioral Health Populations. Valid values are: GEN: General Mental Health Population SMI: Serious Mental Illness Population SED: Serious Emotional Disability Population
Child/Adult	A code value to designate the age group of the population. The Member's age is determined based on the first date of service for the procedure as reported on the claim. Valid values are: A = Adults age 18 and over. C = Children age 17 and under.
Units	The total number of allowed units of service paid for by the MCO or the MCO subcontractor during the month that is reported.
Users	The total number of unduplicated Members for which an allowable service

	was paid for by the MCO or the MCO subcontractor during the month that is reported.
Provider Billed Amount	Total of billed charges for allowable units as reported on the claim.
MCO Paid Amount	Total amount paid by the MCO or the MCO subcontractor for allowable units during the month that is reported.
Denied Count	The number of claim line item details denied by the MCO or the MCO subcontractor during the month that is reported.
Denied Billed Amount	Total of billed charges for the claim line item details denied by the MCO or the MCO subcontractor during the month that is reported.

Report #:	101	Created:	10/16/2011
Name:	Behavioral Health Evidence Based Practices	Last Revised:	11/29/2011
Group:	Mental Health and Substance Abuse	Report Status:	Active
Frequency:	Monthly	Exhibits:	G, I
Period:	Multiple (Monthly, Quarterly, SFY, FFY)		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:

The report identifies utilization of Evidence Based Practices provided for the Behavioral Health Populations. The report also includes all adults and children/youth enrolled with the MCO and all adult SMI and Children/youth SED Behavioral Health Populations enrolled in the MCO for comparison purposes.

Sample Layout:

	Unduplicated User Count	Percentage	Units of Services Count	MCO Paid	All Other Paid	Total Payments Amounts
MCO Enrolled						
All Adults						
All Children/Youth						

	mm/yyyy					
	Unduplicated User Count	Percentage	Units of Services Count	MCO Paid Amount	All Other Paid Amount	Total Payments Amount
BH Users						
All BH Adults						

SMI						
SMI Receiving Peer Support						
SMI Receiving Assertive Community Treatment						
SMI Receiving Supported Employment						
SMI Receiving Supported Housing						
SMI Receiving Family Psychoeducation						
SMI Receiving Integrated Treatment for co-occurring MH/SA disorders						
SMI Receiving Illness Management/Recovery						
SMI Receiving Medication Management						
All BHChildren/Youth						
SED						
SED Receiving Peer Support						
SED Receiving Motivational Interviewing						
SED Receiving Incredible Years						
SED Receiving Parent Child Interaction Therapy						
SED Receiving a form of Cognitive Behavioral Therapy						
SED Receiving Wraparound						
SED Receiving a Standardized Trauma Screening						

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Period to be Reported	Reported periods are to be determined as follows: Month — The first day of the month through the last day of the month. Quarter — The first day of the quarter through the last day of the quarter. Year — The first day of the year through the last day of the year.

Row Label	Description
Unduplicated Count	

MCO Enrolled	Include only Members for which the MCO has received a capitation payment. Unduplicated counts for each reported period are to be determined as follows: Month — Unduplicated count of all Members from the first day of the month to the last day of the month. Quarter — Unduplicated count of all Members from the first day of the quarter to the last day of the quarter. Year — Unduplicated count of Members from the first day of the year through the last day of the year.
MCO Enrolled: All Adults	An unduplicated count of all MCO enrolled Members that are age 18 or older.
MCO Enrolled: All Children/Youth	An unduplicated count of all MCO enrolled Members that are under age 18.
BH Users	Include only Members for which payment has been made for any MH/SA Procedure Code. Unduplicated counts for each reported period are to be determined as follows: Month — Unduplicated count of all users from the first day of the month to the last day of the month. Quarter — Unduplicated count of all users from the first day of the quarter to the last day of the quarter. Year — Unduplicated count of users from the first day of the year through the last day of the year.
BH Users: All Adults	An unduplicated count of all MCO enrolled Members that are age 18 or older and for which payment has been made for any MH/SA Procedure Code
BH Users: SMI	An unduplicated count of all MCO users that are SMI. The SMI Behavioral Health Population is defined in Exhibit G: Behavioral Health Populations.
BH Users: SMI Receiving Peer Support	An unduplicated count of all MCO users that are SMI who have received peer support services during the reporting period.
BH Users: SMI Receiving Assertive Community Treatment	An unduplicated count of all MCO users that are SMI who have received Assertive Community Treatment during the reporting period.
BH Users: SMI Receiving Supported Employment	An unduplicated count of all MCO users that are SMI who have received Supported Employment during the reporting period.
BH Users: SMI Receiving Supported Housing	An unduplicated count of all MCO users that are SMI who have received Supported Housing during the reporting period.
BH Users: SMI Receiving Family Psychoeducation	An unduplicated count of all MCO users that are SMI who have received Family Psychoeducation during the reporting period.
BH Users: SMI Receiving Integrated Treatment for Co-Occurring MH/SA Disorders	An unduplicated count of all MCO users that are SMI who have received Integrated Treatment for Co-Occurring MH/SA Disorders during the reporting period.
BH Users: SMI Receiving Illness Management / Recovery	An unduplicated count of all MCO users that are SMI who have received Illness Management / Recovery during the reporting period.
BH Users: SMI Receiving Medication Management	An unduplicated count of all MCO users that are SMI who have received Medication Management during the reporting period.
BH Users: All BH Children/Youth	An unduplicated count of all MCO enrolled Members that are under age

	18 and for which payment has been made for any MH/SA Procedure Code
BH Users: SED	An unduplicated count of all MCO users that are SED. The SED Behavioral Health Population is defined in Exhibit G: Behavioral Health Populations.
BH Users: SED Peer Support	An unduplicated count of all MCO users that are SED who have received Peer Support during the reporting period.
BH Users: SED Receiving Motivational Interviewing	An unduplicated count of all MCO users that are SED who have received Motivational Interviewing during the reporting period.
BH Users: SED Receiving Incredible Years	An unduplicated count of all MCO users that are SED who have received Incredible Years during the reporting period.
BH Users: SED Receiving Parent Child Interaction Therapy	An unduplicated count of all MCO users that are SED who have received Parent Child Interaction Therapy during the reporting period.
BH Users: SED a form of Cognitive Behavioral Therapy	An unduplicated count of all MCO users that are SED who have received a form of Cognitive Behavioral Therapy during the reporting period.
BH Users: SED Receiving Wraparound	An unduplicated count of all MCO users that are SED who have received Wraparound during the reporting period.
BH Users: SED Receiving Assessment for Trauma History	An unduplicated count of all MCO users that are SED who have received a Standardized Screening for Trauma History during the reporting period.
Percentage	
% of BH Users: to MCO Enrolled	Calculated using 'Users of BH Services' and 'MCO Enrolled'
% of BH Users: All BH Adults to MCO Enrolled All Adults	Calculated using 'BH Users: 'All BH Adults' divided by 'MCO Enrolled: All Adults'
% of BH Users: SMI to MCO Enrolled All Adults	Calculated using 'BH Users: 'SMI' divided by 'MCO Enrolled: All Adults'
% of BH Users: SMI receiving Peer Support Services to BH Users SMI	Calculated using 'BH Users: 'SMI receiving Peer Support' divided by 'BH Users SMI'
% of BH Users: SMI receiving Assertive Community Treatment to BH Users SMI	Calculated using 'BH Users: 'SMI receiving Assertive Community Treatment' divided by 'BH Users SMI'
% of BH Users: SMI receiving Supported Employment to BH Users SMI	Calculated using 'BH Users:: ' SMI receiving Supported Employment' divided by 'BH Users SMI'
% of BH Users: SMI receiving Supported Housing to BH Users SMI	Calculated using 'BH Users: 'SMI receiving Supported Housing' divided by 'BH Users SMI'
% of BH Users: SMI receiving Family Psychoeducation to BH Users SMI	Calculated using 'BH Users: SMI receiving Family Psychoeducation' divided by 'BH Users SMI'
% of BH Users: SMI receiving Integrated Treatment for Co-Occurring MH/SA Disorders to BH Users SMI	Calculated using 'BH Users: SMI receiving Integrated Treatment for Co-Occurring MH/SA Disorders' divided by 'BH Users SMI'
% of BH Users: SMI receiving Illness Management/Recovery to BH Users SMI	Calculated using 'BH Users: SMI receiving Illness Management/Recovery' divided by 'BH Users SMI'
% of BH Users: SMI receiving Medication Management to BH Users SMI	Calculated using 'BH Users: SMI receiving Medication Management' divided by 'BH Users SMI'
% of BH Users: SMI receiving Peer Support Services to BH Users SMI	Calculated using 'BH Users: SMI receiving Peer Support Services' divided by 'BH Users SMI'
% of BH Users: All BH	Calculated using 'BH Users: All BH Children/youth ' divided by 'MCO

Children/youth to MCO Enrolled All Children/Youth	Enrolled: All Children/Youth'
% of BH Users: SED to MCO Enrolled All Children/Youth	Calculated using 'BH Users: SED' divided by 'MCO Enrolled: All Children/Youth
% of BH Users: SED receiving Peer Support to BH Users SED	Calculated using 'BH Users: SED receiving Peer Support' divided by 'BH Users SED'
% of BH Users: SED receiving Motivational Interviewing to BH Users SED	Calculated using 'BH Users: SED receiving Motivational Interviewing' divided by 'BH Users SED'
% of BH Users: SED receiving Incredible Years to BH Users SED	Calculated using 'BH Users: SED receiving Incredible Years' divided by 'BH Users SED'
% of BH Users: SED receiving Parent Child Interaction Therapy to BH Users SED	Calculated using 'BH Users: SED receiving Parent Child Interaction Therapy' divided by 'BH Users SED'
% of BH Users: SED receiving a form of Cognitive Behavioral Therapy to BH Users SED	Calculated using 'BH Users: SED receiving a form of Cognitive Behavioral Therapy' divided by 'BH Users SED'
% of BH Users: SED receiving Wraparound to BH Users SED	Calculated using 'BH Users: SED receiving Wraparound' divided by 'BH Users SED'
% of BH Users: SED receiving Standardized Screening for Trauma History to BH Users SED	Calculated using 'BH Users: SED receiving Standardized Screening for Trauma History' divided by 'BH Users SED'
Units of Service	Count of all allowable units of service from MH/SA Procedure Codes that were provided during the reporting period.
MCO Paid	All payments made by the MCO or the MCO subcontractor made for services provided to members during the reporting period.
All Other Paid	All other Third Party Liability (TPL) payments reported on the claims during the reporting period for the following rows
Total Payments Amount	For each row, calculate the sum amount across the rows for 'MCO Paid', 'All Other Paid'.

Column Label	Description
<mm/yyyy>	The month that is reported. Display in the format mm/yyyy.
QE <mm/dd/yyyy>	Quarter Ending (QE) is the last day of the quarter displayed in the format mm/dd/yyyy. This column is only to be populated when the reported month is 03, 06, 09 or 12.
State Fiscal Year	The State Fiscal Year (SFY) is defined as the period July 01 through June 30. Example: SFY 2012 is defined as the period 01-Jul-2011 through 30-Jun-2012. The SFY identified as the year that the month being reported is in.

Report #:	101A	Created:	10/27/2011
Name:	Behavioral Health Annual Wellness	Last Revised:	10/27/2011
Group:	Mental Health and Substance Abuse	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	State Fiscal Year		
Due Date:	July 15th - By the 15th of the month following the state fiscal year.		

Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:

The report associates annual wellness checks provided to Behavioral Health populations by Procedure Code. All claims activity paid during the reporting period is to be reported.

Sample Layout:

	State Fiscal Year					
	Unduplicated User Count	Percentage to MCO Enrolled	Units Paid	MCO Paid Amount	All Other Paid Amount	Total Payments
MCO Enrolled						
All Adults						
SMI						
All Children/Youth						
SED						

	State Fiscal Year					
	Unduplicated User Count	Percentage to MCO Enrolled	Average Number of PCP Visits	MCO Paid Amount	All Other Paid Amount	Total Payments
Wellness - Visits to Primary Care Provider - All procedures						
All Adults						
BH Adults						
SMI						
All Children/Youth						
BH Children/Youth						
SED						

	State Fiscal Year					
(subset of above)	Unduplicated User Count	Percentage to MCO Enrolled	Units Paid	MCO Paid Amount	All Other Paid Amount	Total Payments

Wellness - Visit to Primary Care Provider - Only Annual Wellness Check/Health Exam Procedures						
All Adults						
BH Adults						
SMI						
All Children/Youth						
BH Children/Youth						
SED						

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by: MH/SA Procedure Code by MH/SA Procedure Code Modifier.

Row Label	Description
MCO Enrolled	Include only Members for which the MCO has received a capitation payment. Unduplicated counts for each reported period are to be determined as follows: Month — Unduplicated count of all Members from the first day of the month to the last day of the month. Quarter — Unduplicated count of all Members from the first day of the quarter to the last day of the quarter. Year — Unduplicated count of Members from the first day of the year through the last day of the year.
MCO Enrolled: All Adults	All MCO enrolled Members that are age 18 or older.
MCO Enrolled: SMI	All MCO enrolled Members that are age 18 or older and are SMI.
MCO Enrolled: All Children/Youth	All MCO enrolled Members that are under age 18.
MCO Enrolled: SED	All MCO enrolled Members that are under age 18 and are SED.
Wellness - Visit to Primary Care Provider – All Procedure Codes	Include only Members for which payment has been made for any Procedure Code associated with a visit to the Primary Care Provider. Unduplicated counts for each reported period are to be determined as follows: Month — Unduplicated count of all users from the first day of the month to the last day of the month. Quarter — Unduplicated count of all users from the first day of the quarter to the last day of the quarter. Year — Unduplicated count of users from the first day of the year through the last day of the year.

Wellness - Visit to Primary Care Provider – All Procedure Codes All Adults	All MCO enrolled Members that are age 18 or older and for which payment has been made for any Procedure Code associated with a Primary Care Provider visit.
Wellness - Visit to Primary Care Provider – All Procedure Codes BH Adults	All MCO enrolled Members that are BH population clients age 18 or older and for which payment has been made for any Procedure Code associated with a Primary Care Provider visit.
Wellness - Visit to Primary Care Provider – All Procedure Codes SMI	All MCO users that are SMI for whom which payment has been made for any Procedure Code associated with a Primary Care Provider visit. The SMI Behavioral Health Population is defined in Exhibit G: Behavioral Health Populations.
Wellness - Visit to Primary Care Provider – All Procedure Codes All Children/Youth	All MCO enrolled Members that are age under 18 and for which payment has been made for any Procedure Code associated with a Primary Care Provider visit.
Wellness - Visit to Primary Care Provider – All Procedure Codes BH Children/Youth	All MCO enrolled Members that are BH population clients age under 18 and for which payment has been made for any Procedure Code associated with a Primary Care Provider visit.
Wellness - Visit to Primary Care Provider – All Procedure Codes SED	All MCO users that are SED for whom which payment has been made for any Procedure Code associated with a Primary Care Provider visit. The SED Behavioral Health Population is defined in Exhibit G: Behavioral Health Populations.
Wellness – Visit to Primary Care Provider - Only Wellness Check / Health Exam	Include only Members for which payment has been made for any Wellness Check Procedure Code. The following are procedure codes that may indicate an annual Wellness Check / Health Exam ('99381', '99382', '99383', '99384', '99385', '99386', '99387', '99391', '99392', '99393', '99394', '99395', '99396', '99397') OR ('99201', '99202', '99203', '99204', '99205', '99211', '99212', '99213', '99214', '99215' AND diagnosis 'V70.0' or 'V20.2) Unduplicated counts for each reported period are to be determined as follows: Month — Unduplicated count of all users from the first day of the month to the last day of the month. Quarter — Unduplicated count of all users from the first day of the quarter to the last day of the quarter. Year — Unduplicated count of users from the first day of the year through the last day of the year.
Wellness - Visit to Primary Care Provider - Only Wellness Check / Health Exam All Adults	All MCO enrolled Members that are age 18 or older and for which payment has been made for any Wellness Check /Health Exam Procedure Code.

Wellness - Visit to Primary Care Provider - Only Wellness Check / Health Exam BH Adults	All MCO enrolled Members that are BH population clients age 18 or older and for which payment has been made for any Wellness Check/Health Exam Procedure Code.
Wellness - Visit to Primary Care Provider - Only Wellness Check / Health Exam SMI	All MCO users that are SMI for whom which payment has been made for any Wellness Check/Health Exam Procedure Code. The SMI Behavioral Health Population is defined in Exhibit G: Behavioral Health Populations.
Wellness - Visit to Primary Care Provider - Only Wellness Check / Health Exam All Children/Youth	All MCO enrolled Members that are age under 18 and for which payment has been made for any Wellness Check /Health Exam Procedure Code.
Wellness - Visit to Primary Care Provider - Only Wellness Check / Health Exam BH Children/Youth	All MCO enrolled Members that are BH population clients age under 18 and for which payment has been made for any Wellness Check/Health Exam Procedure Code.
Wellness - Visit to Primary Care Provider - Only Wellness Check / Health Exam SED	All MCO users that are SED for whom which payment has been made for any Wellness Check/Health Exam Procedure Code. The SED Behavioral Health Population is defined in Exhibit G: Behavioral Health Populations.

Column Label	Description
Unduplicated Count	The total number of unduplicated Members for which an allowable service was paid for by the MCO or the MCO subcontractor during the month that is reported.
Unduplicated Count MCO Enrolled	Include only Members for which the MCO has received a capitation payment. Unduplicated counts for each reported period are to be determined as follows: Month — Unduplicated count of all Members from the first day of the month to the last day of the month. Quarter — Unduplicated count of all Members from the first day of the quarter to the last day of the quarter. Year — Unduplicated count of Members from the first day of the year through the last day of the year.
Unduplicated User Count Wellness - Visit to Primary Care Provider – All Procedure Codes	All MCO enrolled Members for which payment has been made for any Procedure Code associated with a Primary Care Provider visit.

Unduplicated Count Visit to Primary Care Provider - Only Wellness Check / Health Exam	Include only Members receiving a Procedure Code for Wellness Check / Health Exam. The following are procedure codes that may indicate an annual Wellness Check / Health Exam ('99381', '99382', '99383', '99384', '99385', '99386', '99387', '99391', '99392', '99393', '99394', '99395', '99396', '99397') OR ('99201', '99202', '99203', '99204', '99205', '99211', '99212', '99213', '99214', '99215' AND diagnosis 'V70.0' or 'V20.2) Unduplicated counts for each reported period are to be determined as follows: Month — Unduplicated count of all Members from the first day of the month to the last day of the month. Quarter — Unduplicated count of all Members from the first day of the quarter to the last day of the quarter. Year — Unduplicated count of Members from the first day of the year through the last day of the year.
Percentage	
% of Wellness - Visit to Primary Care Provider – All Procedure Codes to MCO Enrolled	Calculated using 'Visit to Primary Care Provider – All Procedure Codes' divided by 'MCO Enrolled'
% of Wellness - Visit to Primary Care Provider – All Procedure Codes: All Adults to MCO Enrolled All Adults	Calculated using 'Visit to Primary Care Provider – All Procedure Codes: All Adults' divided by 'MCO Enrolled: All Adults'
% of Wellness - Visit to Primary Care Provider – All Procedure Codes: BH Adults to MCO Enrolled All Adults	Calculated using 'Visit to Primary Care Provider – All Procedure Codes: BH Adults' divided by 'MCO Enrolled: All BH Adults'
% of Wellness - Visit to Primary Care Provider – All Procedure Codes: SMI to MCO Enrolled All SMI Adults	Calculated using 'Visit to Primary Care Provider – All Procedure Codes: SMI' divided by 'MCO Enrolled: SMI'
% of Wellness - Visit to Primary Care Provider – All Procedure Codes: All Children/Youth to MCO Enrolled All Children/Youth	Calculated using 'Visit to Primary Care Provider – All Procedure Codes: All Children/Youth' divided by 'MCO Enrolled: All Children/Youth'
% of Wellness - Visit to Primary Care Provider – All Procedure Codes: BH Children/Youth to MCO Enrolled All Children/Youth	Calculated using 'Visit to Primary Care Provider – All Procedure Codes: BH Children/Youth' divided by 'MCO Enrolled: All BH Children/Youth'
% of Wellness - Visit to Primary Care Provider – All Procedure Codes: SED to MCO Enrolled All SED Children/Youth	Calculated using 'Visit to Primary Care Provider – All Procedure Codes: SED' divided by 'MCO Enrolled: SED'
% of Wellness - Visit to Primary Care Provider - **Only** Wellness Check / Health Exam to MCO Enrolled	Calculated using 'Visit to Primary Care Provider - **Only** Wellness Check / Health Exam' divided by 'MCO Enrolled'
% of Wellness - Visit to Primary Care	Calculated using 'Visit to Primary Care Provider - **Only** Wellness Check /

Provider - **Only** Wellness Check / Health Exam: All Adults to MCO Enrolled All Adults	Health Exam: All Adults' divided by 'MCO Enrolled: All Adults'
% of Wellness - Visit to Primary Care Provider - **Only** Wellness Check / Health Exam: BH Adults to MCO Enrolled All Adults	Calculated using 'Visit to Primary Care Provider - **Only** Wellness Check / Health Exam: BH Adults' divided by 'MCO Enrolled: All BH Adults'
% of Wellness - Visit to Primary Care Provider - **Only** Wellness Check / Health Exam: SMI to MCO Enrolled All SMI Adults	Calculated using 'Visit to Primary Care Provider - **Only** Wellness Check / Health Exam: SMI' divided by 'MCO Enrolled: SMI'
% of Wellness - Visit to Primary Care Provider - **Only** Wellness Check / Health Exam: All Children/Youth to MCO Enrolled All Children/Youth	Calculated using 'Visit to Primary Care Provider - **Only** Wellness Check / Health Exam: All Children/Youth' divided by 'MCO Enrolled: All Children/Youth'
% of Wellness - Visit to Primary Care Provider - **Only** Wellness Check / Health Exam: BH Children/Youth to MCO Enrolled All Children/Youth	Calculated using 'Visit to Primary Care Provider - **Only** Wellness Check / Health Exam: BH Children/Youth' divided by 'MCO Enrolled: All BH Children/Youth'
% of Wellness - Visit to Primary Care Provider - **Only** Wellness Check / Health Exam: SED to MCO Enrolled All SED Children/Youth	Calculated using 'Visit to Primary Care Provider - **Only** Wellness Check / Health Exam: SED' divided by 'MCO Enrolled: SED'
Units Paid	
MCO Enrolled	Count of all allowable units of service from any Procedure Codes during the reporting period. Include only Members for which the MCO has received a capitation payment.
Wellness - Visit to Primary Care Provider - Only Wellness Check / Health Exam	Include only Members for which payment has been made for any Wellness Check / Health Exam Procedure Code.
Average Number of PCP Visits	
Wellness - Visit to Primary Care Provider – All Procedure Codes	Show the average number of personal care provider visits per population reflected in the report.
MCO Paid Amounts	
MCO Enrolled	All payments made by the MCO or the MCO subcontractor made for services provided to Members during the reporting period. Include only Members for which the MCO has received a capitation payment.
Wellness – Visit to Primary Care Provider – All Procedure Codes	All payments made by the MCO or the MCO subcontractor made for all procedure code provided to Members during the reporting period by a primary care provider. Include only Members for which the MCO has received a capitation payment.
Wellness – Visit to Primary Care Provider - Only Wellness Check / Health Exam	All payments made by the MCO or the MCO subcontractor made for Wellness Check / Health Exam procedure code services provided to Members during the reporting period. Include only Members for which the MCO has received a capitation payment.

All Other Paid Amounts	All other Third Party Liability (TPL) payments reported on the claims during the reporting period.
MCO Enrolled	All other TPL payments reported on the claims for services provided to Members during the reporting period by a primary care provider. Include only Members for which the MCO has received a capitation payment.
Wellness – Visit to Primary Care Provider – All Procedure Codes	All other TPL payments reported on the claims for services provided to Members during the reporting period by a primary care provider. Include only Members for which the MCO has received a capitation payment.
Wellness – Visit to Primary Care Provider - Only Wellness Check / Health Exam	All other TPL payments reported on the claims for services provided to Members during the reporting period by a primary care provider. Include only Members for which the MCO has received a capitation payment.
Total Payments Amount	For each row, calculate the sum amount across the rows for 'MCO Paid', 'All Other Paid'.

Report #:	102	Created:	10/27/2011
Name:	Behavioral Health and Chronic Physical Health	Last Revised:	01/23/2012
Group:	Mental Health and Substance Abuse	Report Status:	Active
Frequency:	Monthly	Exhibits:	G, K
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:

The report identifies the chronic physical health issues (Exhibit K) associated with children and adults who also are defined as one of the four major Behavioral Health populations as defined in Exhibit G. All claims activity paid or denied during the reporting period is to be reported. All provider types billing for mental health and substance abuse services are to be reported.

Sample Layout:

MCO Region		Provider Type	Chronic Physical Health Dx	Behavioral Health Population	Child/Adult	Units Paid	Users Count	Provider Billed Amount	MCO Paid Amount	Units Denied Count	Denied Billed Amount
Provider	Member										

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in order: MCO Region: Provider (ascending), Provider ID (ascending), MH/SA Procedure Code (ascending) and Procedure Code Modifier (ascending).

Row Label	Description
NA	NA

Column Label	Description
Provider ID	The Provider's Medicaid ID.
MCO Region: Provider	The Medical Region of the Provider location where the service was rendered. Report as a two character field. Valid values for services provided in Kentucky are 01 through 08. Services provided out of state are to be reported as 09.
MCO Region: Member	The Medical Region of the Member's residence. Report as a two character field. Valid values are 01 through 08.
Provider Type	All Provider Types billing for MH/SA procedure codes are to be listed. Billing Provider Type is designated with a state specific two (2) character field. Crosswalk of Provider Type and Provider Specialty to each Provider Description is provided in Exhibit A: Provider Type and Specialty Crosswalk.
Chronic Physical Health Dx	The ICD-9 (or most current code in use) for the chronic physical health illness. A listing of Chronic Physical Health Diagnoses of interest to BHDID is provided in Exhibit K. The chronic physical health codes listed in Exhibit K are provided as a guide and may change based on industry practices.
Behavioral Health Population	A code value to designate the population for which the MH/SA service was provided. Populations are defined in Exhibit G: Behavioral Health Populations. Valid values are: AGEN: Adult General Mental Health Population SMI: Serious Mental Illness Population SED: Serious Emotional Disability Population CGEN: Child/Youth General Mental Health Population For purpose of this report only, 1-year of client service history should be used to identify BH clients who have claims for chronic illness.
Child/Adult	A code value to designate the population. The Member's age is determined based on the first date of service for the procedure as reported on the claim. Valid values are: A = Adults age 18 and over. C = Children under age 18
Units Paid	The total number of allowed units of service paid for by the MCO or the MCO subcontractor during the month that is reported.
Unduplicated User Count	The total number of unduplicated Members for which an allowable service

	was paid for by the MCO or the MCO subcontractor during the month that is reported.
Provider Billed Amount	Total of billed charges for allowable units as reported on the claim.
MCO Paid Amount	Total amount paid by the MCO or the MCO subcontractor for allowable units during the month that is reported.
Units Denied Count	The number of claim line item details denied by the MCO or the MCO subcontractor during the month that is reported.
Denied Billed Amount	Total of billed charges for the claim line item details denied by the MCO or the MCO subcontractor during the month that is reported.

Report #:	103	Created:	10/27/2011
Name:	Behavioral Health PRTF and Inpatient Readmissions	Last Revised:	2/17/2012
Group:	Mental Health and Substance Abuse	Report Status:	Active
Frequency:	Monthly	Exhibits:	G
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:

The report identifies the percentage of readmissions among PRTFs and inpatient facilities for Behavioral Health clients as defined in Exhibit G. All claims activity paid or denied during the reporting period is to be reported. All provider types billing for mental health and substance abuse services are to be reported. The readmissions are defined as a discharge from the facility type in the row and readmitted to any other type of facility listed. The following are to be excluded from the contents of this report: 1) transfers or same day readmissions, 2) deaths, 3) discharges to acute medical care facilities.

Sample Layout:

	mm/yyyy											
	MCO Region (of Provider)	Count of all MCO enrollees	Number of Admissions	Average Length of Stay	Readmissions							
					7 days		**30 days**		**60 days**		**90 days**	
					Number of Readmissions	Percent of Readmissions	Number of Readmissions	Percent of Readmissions	Number of Readmissions	Percent of Readmissions	Number of Readmissions	Percent of Readmissions
MCO Enrolled	All Regions											
	01											
	02											

	03											
	04											
	05											
	06											
	07											
	08											
	09											
All Adults	All Regions											
	01											
	02											
	03											
	04											
	05											
	06											
	07											
	08											
	09											
BH Adults	All Regions											
	01											
	02											
	03											
	04											
	05											
	06											
	07											
	08											
	09											
All Children/Youth	All Regions											
	01											
	02											
	03											
	04											
	05											
	06											
	07											
	08											
	09											
BH Children/Youth	All Regions											

	01											
	02											
	03											
	04											
	05											
	06											
	07											
	08											
	09											
	mm/yyyy											
		BH Population (Exhibit G)	Number of Admissions	Average Length of Stay	Readmissions							
					7 days		**30 days**		**60 days**		**90 days**	
Discharged From:	MCO Region (of Provider)				Number of Readmissions	Percent of Readmissions	Number of Readmissions	Percent of Readmissions	Number of Readmissions	Percent of Readmissions	Number of Readmissions	Percent of Readmissions
1. Acute Psychiatric (Private Psychiatric units)	**All**											
	01	AGEN										
	01	SMI										
	01	SED										
	01	CGEN										
	02	AGEN										
	02	SMI										
	02	SED										
	02	CGEN										
	etc											
2. PRTF - Level I	**ALL**											
	01	AGEN										
	01	SMI										
	01	SED										
	01	CGEN										
	02	AGEN										
	02	SMI										
	02	SED										
	02	CGEN										

	etc											
3. PRTF - Level II	**All**											
	01	AGEN										
	01	SMI										
	01	SED										
	01	CGEN										
	02	AGEN										
	02	SMI										
	02	SED										
	02	CGEN										
	etc											
4. IMD State Psychiatric Facilities	**All**											
	01	AGEN										
	01	SMI										
	01	SED										
	01	CGEN										
	02	AGEN										
	02	SMI										
	02	SED										
	02	CGEN										
	etc											
5a. EPSDT Substance Abuse Residential	**All**											
	01	AGEN										
	01	SMI										
	01	SED										
	01	CGEN										
	02	AGEN										
	02	SMI										
	02	SED										
	02	CGEN										
	etc											
5b. EPSDT Out of State	**All**											
	01	AGEN										
	01	SMI										
	01	SED										
	01	CGEN										
	02	AGEN										
	02	SMI										

	02	SED										
	02	CGEN										
	etc											

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in order: MCO Region: Provider (ascending), Provider ID (ascending), MH/SA Procedure Code (ascending) and Procedure Code Modifier (ascending).

Row Label	Description
1. Acute Psychiatric (Private Psychiatric units) 2. PTRF I 3. PRTF II 4. IMD State Psychiatric Facilities 5a. EPSDT SA Residential 5b. EPSDT Out of State	These are defined by the Provider Type field.

Column Label	Description
Provider ID	The Provider's Medicaid ID.
MCO Region: Provider	The Medical Region of the Provider location where the service was rendered. Report as a two character field. Valid values for services provided in Kentucky are 01 through 08. Services provided out of state are to be reported as 09.
Count of all MCO Enrollees	The count of unique members of the panel for the reporting period.
Number of Admissions	Count of admissions during the reporting period to any of the following facilities: 1. Acute Psychiatric (Private Psychiatric units) 2. PTRF I 3. PRTF II 4. IMD State Psychiatric Facilities 5a. EPSDT SA Residential 5b. EPSDT Out of State These are represented in the Provider Type field.
Average Length of Stay (LOS)	The average number of days that the facility stay lasted; the number of days beginning with the day of admission and ending with the day of discharge. The admission day and discharge day are each counted as a day. For the top portion only, include for the baseline the average LOS for the rows indicated.
Behavioral Health Population	A code value to designate the population for which the MH/SA service was provided. Populations are defined in Exhibit G: Behavioral Health Populations. Valid values are: AGEN: Adult General Mental Health Population SMI: Serious Mental Illness Population

	SED: Serious Emotional Disability Population CGEN: Child/Youth General Mental Health Population
Readmission	The readmissions are defined as a discharge from the facility type in the row and readmitted to any other type of facility listed below. 1. Acute Psychiatric (Private Psychiatric units) 2. PTRF I 3. PRTF II 4. IMD State Psychiatric Facilities 5a. EPSDT SA Residential 5b. EPSDT Out of State The following are to be excluded from the contents of this report: 1) transfers or same day readmissions, 2) deaths, 3) discharges to acute medical care facilities. Each monthly report will include the admissions for that reporting period. The admission is counted as a readmission when a previous admission date occurred 7, 30, 60, or 90 days prior given historical data back to November 1, 2011.
Percent Readmission	Numerator: the number of admissions for the row. Denominator: the number of readmissions for the row per time category (7,30. 60. or 90 days).

Report #:	104	Created:	10/31/2011
Name:	Behavioral Health Expenses (PMPM)	Last Revised:	03/08/2012
Group:	Mental Health and Substance Abuse	Report Status:	Active
Frequency:	Monthly	Exhibits:	G, "red book"
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:

The report identifies per member per month expenses for Behavioral Health populations. All claims activity paid or denied during the reporting period is to be reported. All provider types billing for mental health and substance abuse services are to be reported.

Sample Layout:

mm/yy	All MCO Enrollees	All BH Adults	SMI	All BH Children / Youth	SED

Total Cost Per Member Per Month (PMPM)					
Medical Costs Per Member Per Month (PMPM)					
Medical Pharmacy Costs Per Member Per Month (PMPM)					
Behavioral Health Cost (PMPM)					
Behavioral Health Pharmacy Costs Per Member Per Month (PMPM)					
Behavioral Health Medical Cost Ratio					

QE mm/dd/yyyy

Total Cost Per Member Per Quarter (PMPQ)					
Medical Costs Per Member Per Quarter (PMPQ)					
Medical Pharmacy Costs Per Member Per Quarter (PMPQ)					
Behavioral Health Cost (PMPQ)					
Behavioral Health Pharmacy Costs Per Member Per Quarter (PMPQ)					
Behavioral Health Medical Cost Ratio					

State Fiscal Year

Total Cost Per Member Per State Fiscal Year					
Medical Costs Per Member Per State Fiscal Year					
Medical Pharmacy Costs Per Member Per State Fiscal Year					
Behavioral Health Pharmacy Costs Per Member Per Fiscal Year					
Behavioral Health Cost per Fiscal Year					
Behavioral Health Medical Cost Ratio					

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy The following describes each reported period: Month — from the first day of the month to the last day of the month. Quarter — from the first day of the quarter to the last day of the quarter.

	Year from the first day of the year through the last day of the year.
Sort Order	The report has no specific sort order.

Row Label	Description
Total Cost Per Member per (month, quarter, year)	per member per (month, quarter, year) cost. "Total Cost" = "Medical Cost" + "Medical Pharmacy Cost" + "Behavioral Health Costs" + "Behavioral Health Pharmacy Cost"
Medical Costs Per Member per (month, quarter, year)	per member per (month, quarter, year): All medical costs excluding medical pharmacy costs**.**
Medical Pharmacy Costs Per Member per (month, quarter, year)	per member per (month, quarter, year): All medical pharmacy costs**.**
Behavioral Health Costs	per member per (month, quarter, year): All behavioral health costs excluding behavioral health pharmacy costs.
Behavioral Health Pharmacy Costs Per Member per (month, quarter, year)	per member per (month, quarter, year): All behavioral health pharmacy costs**.**
Behavioral Health Medical Cost Ratio	per member per (month, quarter, year): All behavioral health costs (including behavioral health pharmacy costs) divided by all medical costs (including medical pharmacy costs).

Column Label	Description
All MCO Enrollees	Include only Members for which the MCO has received a capitation payment.
All BH Adults	All MCO enrolled members that are BH population clients age 18 or older. Populations are defined in Exhibit G: Behavioral Health Populations.
SMI	All MCO enrolled members that are SMI. Populations are defined in Exhibit G: Behavioral Health Populations.
All BH Children / Youth	All MCO enrolled members that are BH population clients age under 18. Populations are defined in Exhibit G: Behavioral Health Populations.
SED	All MCO enrolled members that are SED. Populations are defined in Exhibit G: Behavioral Health Populations.

Report #:	106	Created:	12/05/2011
Name:	Behavioral Health Pharmacy for MCO Members - Adults and Children	Last Revised:	12/09/2011
Group:	Mental Health and Substance Abuse	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, B, G, J
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:

The report identifies behavioral health pharmacy prescribed for all members – adults and children. All claims activity paid or denied during the reporting period is to be reported. All prescriber types billing for pharmacy are to be reported.

Sample Layout:

Monthly Baseline:

Number of members in age class:

0-5	_____
6-12	_____
13-17	_____
18-64	_____
65+	_____

Polypharmacy Adults

Percent of all adult members on 2 or more psychiatric medications _____.

Percent of all adult members on 3 or more psychiatric medications _____.

Percent of all adult members on 4 or more psychiatric medications _____.

Percent of all adult members on 5 or more psychiatric medications _____.

Polypharmacy Children

Percent of all child members on 2 or more psychiatric medications _____.

Percent of all child members on 3 or more psychiatric medications _____.

Percent of all child members on 4 or more psychiatric medications _____.

Percent of all child members on 5 or more psychiatric medications _____.

Intra-class Polypharmacy Adults

Percent of all MCO adult members on 2 or more psychiatric medications of the same class for more than 30 days.

Antianxiety _____.
Antidepressants _____.
Antipsychotics _____.
CNS Stimulants _____.
Mood Stabilizers _____.
Other Psychotropics _____.
Substance Abuse meds _____.

Intra-class Polypharmacy Children

Percent of all MCO children on 2 or more psychiatric medications of the same class for more than 30 days.

Antianxiety _____.

Antidepressants _____.
Antipsychotics _____.
CNS Stimulants _____.
Mood Stabilizers _____.
Other Psychotropics _____.
Substance Abuse meds _____.

Behavioral Health Pharmacy for All MCO Members - Adults and Children															
MCO Region				Rx Date				Diagnosis Class							
Provider	Member	Provider Type	Med Class	Month	Year	Behavioral Health Population	Age Class	psychiatric	non-psychiatric	formulary/non-formulary	Provider Billed Amount	MCO Paid Amount	Denied Count	Denied Billed Amount	Reason for Denial

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in order: MCO Region: Provider (ascending), Provider ID (ascending), Provider Type (ascending), and Med Class (Exhibit J).

Row Label	Description
Polypharmacy Adults	
Percent of all adult members on 2 or more psychiatric medications	Numerator: number of all MCO adult members (>18 years age) on 2 or more psychiatric medications (in any class listed on Exhibit J) during the reporting period. Denominator: number of all MCO adult members (>18 years age) during the reporting period.
Percent of all adult members on 3 or more psychiatric medications	Numerator: number of all MCO adult members (>18 years age) on 3 or more psychiatric medications (in any class listed on Exhibit J) during the reporting period. Denominator: number of all MCO adult members (>18 years age) during the reporting period.
Percent of all adult members on 4 or more psychiatric medications	Numerator: number of all MCO adult members (>18 years age) on 4 or more psychiatric medications (in any class listed on Exhibit J) during the reporting period. Denominator: number of all MCO adult members (>18 years age) during the reporting period.
Percent of all adult members on 5 or more psychiatric medications	Numerator: number of all MCO adult members (>18 years age) on 5 or more psychiatric medications (in any class listed on Exhibit J) during the reporting period. Denominator: number of all MCO adult members (>18 years age) during the reporting period.

Polypharmacy Child	
Percent of all child members on 2 or more psychiatric medications	Numerator: number of all MCO child members (<18 years age) on 2 or more psychiatric medications (in any class listed on Exhibit J) during the reporting period. Denominator: number of all MCO child members (<18 years age) during the reporting period.
Percent of all child members on 3 or more psychiatric medications	Numerator: number of all MCO child members (<18 years age) on 3 or more psychiatric medications (in any class listed on Exhibit J) during the reporting period. Denominator: number of all MCO child members (<18 years age) during the reporting period.
Percent of all child members on 4 or more psychiatric medications	Numerator: number of all MCO child members (<18 years age) on 4 or more psychiatric medications (in any class listed on Exhibit J) during the reporting period. Denominator: number of all MCO child members (<18 years age) during the reporting period.
Percent of all child members on 5 or more psychiatric medications	Numerator: number of all MCO child members (<18 years age) on 5 or more psychiatric medications (in any class listed on Exhibit J) during the reporting period. Denominator: number of all MCO child members (<18 years age) during the reporting period.
Intra-class Polypharmacy	
ADULTS: Percent of all MCO adult members on 2 or more psychiatric medications of the same class for more than 30 days.	For each class of BH Psychotropic Medication Codes (Exhibit J): Enter the percentage of all MCO adult members who are on more than 2 psychiatric medications (Exhibit J) for more than 30 days. This will require rolling back into the previous month. Numerator: number of all MCO adult members (>18 years age) on 2or more psychiatric medications (in any class listed on Exhibit J) for more than 30 days during the reporting period. Denominator: number of all MCO adult members (>18 years age) during the reporting period.
CHILDREN: Percent of all MCO child members on 2 or more psychiatric medications of the same class for more than 30 days.	For each class of BH Psychotropic Medication Codes (Exhibit J): Enter the percentage of all MCO child members who are on more than 2 psychiatric medications (Exhibit J) for more than 30 days. This will require looking back into the previous month. Numerator: number of all MCO child members (<18 years age) on 2or more psychiatric medications (in any class listed on Exhibit J) for more than 30 days during the reporting period. Denominator: number of all MCO child members (<18 years age) during the reporting period.

Column Label	**Description**
MCO Region: Provider	The Medical Region of the Provider location where the service was rendered. Report as a two character field. Valid values for services provided in Kentucky are 01 through 08. Services provided out of state are to be reported as 09.
MCO Region: Member	The Medical Region of the Member's residence. Report as a two character field. Valid values are 01 through 08.
Provider Type	All Provider Types billing for MH/SA procedure codes are to be listed. Billing Provider Type is designated with a state specific two (2) character

	field. Crosswalk of Provider Type and Provider Specialty to each Provider Description is provided in Exhibit A: 'Provider Type and Specialty Crosswalk' and in Exhibit B 'Provider Type Category Crosswalk'.
Medication Class	The Behavioral Health Med Class code. A listing of Medication Class Codes is provided in Exhibit J: BHDID Psychotropic Medication Class Codes. These codes are provided as a guide and may change based on industry practices.
Prescription Date: Month	A two character designation for the month the drug was originally provided. Valid values are 01 through 12.
Prescription Date: Year	A four character designation for the year the drug was originally provided.
Behavioral Health Population	A code value to designate the population for which the medication was provided. This report includes all MCO members. Valid values are: NON: - Non Behavioral Health Population AGEN: Adult General Mental Health Population SMI: Serious Mental Illness Population SED: Serious Emotional Disability Population CGEN: Child/Youth General Mental Health Population
Age Class	A code value to designate the population. The Member's age is determined based on the first date of service for the procedure as reported on the claim. Valid values are: 1 = age 0-5 years; 2 = age 6-12 years; 3 = age 13-17 years 4 = age 18-64 years; 5 = age 65+ years.
Diagnosis Class: Psychiatric	Enter "yes" if any of any of the member's diagnoses include any behavioral health diagnosis; otherwise check "no".
Diagnosis Class: Non-Psychiatric	Enter "yes" if any of any of the member's diagnoses include any non-behavioral health diagnosis; otherwise check "no".
Formulary/Non-Forumulary	The type of the claim as made by the MCO or the MCO subcontractor during the month that is reported. Valid values are: F – Formulary; N – Non-formulary
Provider Billed Amount	Total of billed charges for allowable BH pharmacy claims.
MCO Paid Amount	Total amount paid by the MCO or the MCO subcontractor for allowable BH pharmacy claims during the month that is reported.
Denied Count	The number of BH Pharmacy claim line item details denied by the MCO or the MCO subcontractor during the month that is reported.
Denied Billed Amount	Total of billed charges for the BH Pharmacy claim line item details denied by the MCO or the MCO subcontractor during the month that is reported.
Reason for Denial	If denied BH Pharmacy claim, list the codes for reason that the claim was denied.

Report #:	107	Created:	10/11/2011
Name:	Behavioral Health Network Capacity	Last Revised:	1/27/2012
Group:	Providers for Mental Health and Substance Abuse	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:	First calendar day of the month through the last		

	calendar day of the month		
Due Date:	By the 15th of the month following the report period		
Submit to:	KY Department for Behavioral Health, Developmental and Intellectual Disabilities & KY Department for Medicaid Services		

Description:
The report identifies the capacity of the MCO professional network which provides Behavioral Health services to children and adults. The total number of professionals by discipline is to be reported (e.g., Psychiatrists, Master's Level clinicians, Peer Specialists, etc.). Of that total number, it will further be reported by the number of professionals that are associated with each provider type(s) and those working within each MCO region. It is understood that some professionals will be represented in multiple provider type and region categories.
MCO will create data report based on the sample below and provide a geographical map of the state displaying providers (with active claims only) in their network.

Sample Layout: Network Capacity

Behavioral Health Discipline	Total Number of Professionals by Discipline	Total Number with at least 1 Claim Filed During the Report Period	Provider Type															MCO Region (of Provider)											
			02 – Mental Hosp	04 - PRTF	13 – Specialized Ch Clinic	21 – School Based health Srvs	24 – First Steps	25 – Targeted Case Mgmt	27 & 28 Adult and Child TCM	29 – IMPACT Plus	30 - CMHC	31 – Primary Care	40 – EPSDT Prev Srvs.	45 – EPSDT Special	64 & 65 & 95 – Physician Ind	82 – Clinical Social Worker	89 - Psychologist	92 & 93 – Psych /Rehab	Other	1	2	3	4	5	6	7	8	Out of State
Psychiatrist																													
Psychiatrist - Child and Adolescent																													
Physician Assistant																													
Advanced Registered Nurse Practitioner																													
Registered Nurse																													
PhD Psychologist																													
Other PhD																													
Master's Level Psychologist with Autonomous Functioning/ Licensed Psychological																													

Practitioner																												
Master's Level Clinician with License to function Independently (LCSW, LMFT, LPCC, etc.)																												
Master's Level Clinician under supervision (CSW, MFTA, PCCA, etc.)																												
Certified Alcohol and Drug Counselor																												
Juvenile Sex Offender Certified Counselor																												
Certified Sex Offender Treatment Provider																												
Peer Specialist																												
Other: degreed/certified/ licensed																												
Other: Para-Professional (High school/ GED or less)																												

Report the following unique percentages also:

- Percentage of Psychiatrist FTEs / 1000 MCO enrollees who are Behavioral Health clients as defined in Exhibit G.
  Numerator: the total number of Psychiatrist FTEs who provide at least one BH claim during the reporting period
  Denominator: per 1000 of the total number of MCO enrollees who are Behavioral Health clients as defined in Exhibit G.
- Percentage of Psychiatrist FTE- Child and Adolescent FTEs / 1000 MCO enrollees who are Behavioral Health clients as defined in Exhibit G.
  Numerator: the total number of Psychiatrist FTEs who provide at least one BH claim during the reporting period
  Denominator: per 1000 of the total number of MCO enrollees who are Behavioral Health clients as defined in Exhibit G.
- Percentage of Masters Level Clinicians with License to function independently (LCSW, LMFT, LPCC, etc / 1000 MCO enrollees who are Behavioral Health clients as defined in Exhibit G.
  Numerator: the total number of Masters Level Clinicians with License to function independently (LCSW, LMFT, LPCC, etc. who provide at least one BH claim during the reporting period
  Denominator: per 1000 of the total number of MCO enrollees who are Behavioral Health clients as defined in Exhibit G.
- Percentage of Peer Specialists / 1000 MCO enrollees who are Behavioral Health clients as defined in Exhibit G.
  Numerator: the total number of Peer Specialists who provide at least one BH claim during the reporting period
  Denominator: per 1000 of the total number of MCO enrollees who are Behavioral Health clients as defined in Exhibit G.

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	As sample format displays

Row Label	Description
Psychiatrist	MD or OD Eligible or Certified by the American Board of Psychiatry and Neurology whether serving Adults or Children. *http://www.abpn.com*
Psychiatrist - Child and Adolescent	MD or OD Eligible or Certified by the American Board of Psychiatry and Neurology in Child and Adolescent Psychiatry *http://www.abpn.com/sub_cap.html*
Physician Assistant	Licensed in accordance with the KY Board of Medical Licensure KRS 311.844
Advanced Registered Nurse Practitioner http://kbn.ky.gov/	Licensed in accordance with the KY Board of Nursing KRS 314 http://www.lrc.ky.gov/KRS/314-00/042.PDF
Registered Nurse http://kbn.ky.gov/	Credentialed and in good standing in accordance with the KY Board of Nursing.
PhD Psychologist http://psy.ky.gov	Licensed in accordance with the KY Board of Examiners of Psychology KRS 319.
Other PhD	Licensed in accordance with the applicable licensure or credentialing board.
Master's Level Psychologist with Autonomous Functioning/Licensed Psychological Practitioner http://psy.ky.gov	Licensed and in good standing in accordance with the KY Board of Examiners of Psychology KRS 319
Master's Level Clinician with License to function Independently (LCSW, LMFT, LPCC, etc.) http://lpc.ky.gov	Licensed in accordance with applicable credentialing board. **Board of Licensure for Social Work** **335.100 Licensed Clinical Social Worker** Board of Licensure for Marriage and Family Therapists KRS 335.330 **Licensed Professional Counselor** KRS 335.525(1) http://www.lrc.ky.gov/KRS/335-00/500.PDF
Master's Level Clinician under supervision (Social Work, Marriage and Family	Practicing under supervision in accordance with applicable credentialing board. Certified social worker in the practice of clinical social work as provided in KRS 335.080(3).

Therapist (MFT), Counseling,	MFT Associate: Board of Licensure for Marriage and Family Therapists in accordance with KRS 335.330. KRS 335.332 http://www.lrc.ky.gov/KRS/335-00/500.PDF Licensed Professional Counselor Associate KRS 335.525(2)
Certified Alcohol and Drug Counselor http://adc.ky.gov	Board of Alcohol and Drug Counselors in accordance with KRS 309.080 to 309.089. **Note: Pending 2012 legislation may create expanded levels of credentialing for this discipline**
Juvenile Sex Offender Certified Counselor	http://djj.ky.gov/NR/rdonlyres/F9BF0B20-6BC0-4560-BDC8-B63D1B0B07A0/0/800Series.pdf
Certified Sex Offender Treatment Provider	
Peer Specialist	Certified through 908 KAR 2:220 and 908 KAR 2:230
Other: E.g., Professional Equivalent per KY Medicaid,,degreed/certified/licensed other than listed above	907 KAR 1:044 **http://www.lrc.state.ky.us/kar/907/001/044.htm**

Column Label	Description
Provider Type	All Provider Types billing for MH/SA procedure codes are to be listed. Billing Provider Type is designated with a state specific two (2) character field. Crosswalk of Provider Type and Provider Specialty to each Provider Description is provided in Exhibit A: Provider Type and Specialty Crosswalk
MCO Region: Provider	The Medical Region of the Provider location where the service was rendered. Report as a two character field. Valid values for services provided in Kentucky are 01 through 08. Services provided out of state are to be reported as 09.

Report #:	110	Created:	10/15/2011
Name:	Behavioral Health Services by Procedure	Last Revised:	10/16/2011
Group:	Mental Health and Substance Abuse	Report Status:	Active
Frequency:	Monthly	Exhibits:	H
Period:	Multiple (Monthly, SFY, FFY)		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:

The report identifies the utilization of Behavioral Health Services by Procedure Code. All claims activity paid during the reporting period is to be reported.

Sample Layout:

Utilization of Behavioral Health Services by Procedure Code												
MH/SA Procedure Code	MH/SA Procedure Code Description	Procedure Code Modifier	Procedure Code Modifier Description	<MM/YYYY>			SFY <YYYY> to Date			FFY <YYYY> to Date		
				Users	Allowed Units	MCO Paid Amount	Users	Allowed Units	MCO Paid Amount	Users	Allowed Units	MCO Paid Amount

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by: MH/SA Procedure Code by MH/SA Procedure Code Modifier.

Row Label	Description
NA	NA

Column Label	Description
MH/SA Procedure Code	The Procedure Code paid for by the MCO or the MCO subcontractors. A listing of MH/SA Procedure Codes is provided in Exhibit H: MH/SA Procedure Codes. The MH/SA procedure code list is provided as a guide and may change based on industry practices.
MH/SA Procedure Code Description	The Description for the MH/SA Procedure Code.
Procedure Code Modifier	The modifier submitted with the procedure code on the claim.
Procedure Code Modifier Description	The Description for the Procedure Code Modifier.
<mm/yyyy>	The month that is reported.
SFY <yyyy> to Date	The State Fiscal Year (SFY) identified as the year that the month being reported is in. SFY runs from July 01 through June 30. Example: SFY 2012 is defined as the period 01-Jul-2011 through 30-Jun-2012.
FFY <yyyy> to Date	The Federal Fiscal Year (FFY) identified as the year that the month being reported is in. FFY runs from October 01 through September 30. Example: SFY 2012 is defined as the period 01-Oct-2011 through 30-Sep-2012.
<mm/yyyy>: Users	The total number of unduplicated Members for which an allowable service was paid for by the MCO or the MCO subcontractor during the month that is reported.
SFY <yyyy> to Date: Users	The total number of unduplicated Members for which an allowable service was paid for by the MCO or the MCO subcontractor during the State Fiscal Year that is reported.
FFY <yyyy> to Date: Users	The total number of unduplicated Members for which an allowable service was paid for by the MCO or the MCO subcontractor during the Federal Fiscal Year that is reported.

<mm/yyyy>: Allowed Units	The total number of allowed units of service paid for by the MCO or the MCO subcontractor during the month that is reported.
SFY <yyyy> to Date: Allowed Units	The total number of allowed units of service paid for by the MCO or the MCO subcontractor during the State fiscal Year that is reported.
FFY <yyyy> to Date: Allowed Units	The total number of allowed units of service paid for by the MCO or the MCO subcontractor during the Federal Fiscal Year that is reported.
<mm/yyyy>: MCO Paid Amount	Total amount paid by the MCO or the MCO subcontractor for allowable units during the month that is reported.
SFY <yyyy> to Date: MCO Paid Amount	Total amount paid by the MCO or the MCO subcontractor for allowable units during the State Fiscal Year that is reported.
FFY <yyyy> to Date: MCO Paid Amount	Total amount paid by the MCO or the MCO subcontractor for allowable units during the Federal Fiscal Year that is reported.

Report #:	118	Created:	1/27/2012
Name:	Behavioral Health Outcomes Summary	Last Revised:	2/8/2012
Group:	Mental Health and Substance Abuse	Report Status:	Active
Frequency:	Monthly	Exhibits:	G, H, I, J, K
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15th of the month following the report period.		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:

This separate report summarizes outcomes associated with all Behavioral Health data reporting for children and adults. All claims activity paid or denied during the reporting period is to be included in this reported. All provider types billing for mental health and substance abuse services are to be reported.

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in order: MCO Region: Provider (ascending), Provider ID (ascending), MH/SA Procedure Code (ascending) and Procedure Code Modifier (ascending).

Row Label		Description
Reference Data Report #	**Original Report # on Contract**	**Description of Outcomes**
107	B1 a on Appendix K.	**Behavioral Health Network Capacity** MCO will provide report on staffing within the behavioral health network including: a. FTE's per 1000 Chronic Cases (SMI,SED) Percentage of *Psychiatrists FTE* / 1000 MCO enrollees who are one or more of the four Behavioral Health Populations as defined in Exhibit G. • Percentage of Ph.D psychologists / 1000 MCO enrollees who are one or more of

		the four Behavioral Health Populations as defined in Exhibit G. • Percentage of other PhDs / 1000 MCO enrollees who are one or more of the four Behavioral Health Populations as defined in Exhibit G. • Percentage of MA Psychologists / 1000 MCO enrollees who are one or more of the four Behavioral Health Populations as defined in Exhibit G. • Percentage of Total licensed (for independent practice) therapists / 1000 MCO enrollees who are one or more of the four Behavioral Health Populations as defined in Exhibit G. List these by discipline LMFT, MPCC, LCSW, etc. • Percentage of Total master's level therapists under supervision FTE / 1000 MCO enrollees who are one or more of the four Behavioral Health Populations as defined in Exhibit G. List these by discipline LMFT, MPCC, LCSW, etc. • Percentage of MSWs / 1000 MCO enrollees who are one or more of the four Behavioral Health Populations as defined in Exhibit G. • Percentage of BAs / 1000 MCO enrollees who are one or more of the four Behavioral Health Populations as defined in Exhibit G. • Percentage of Targeted Case Managers / 1000 MCO enrollees who are one or more of the four Behavioral Health Populations as defined in Exhibit G. • Percentage of Other Support Staff / 1000 MCO enrollees who are one or more of the four Behavioral Health Populations as defined in Exhibit G. • Percentage of Peer Support Specialists / 1000 MCO enrollees who are one or more of the four Behavioral Health Populations as defined in Exhibit G.

110	B1 b on Appendix K.	**Access: Behavioral Health Service by Procedure Code**
		• Utilization by Chronic Cases (SMI,SED)
		  • Number of crisis calls / 1000 MCO enrollees who are one or more of the four Behavioral Health Populations as defined in Exhibit G.
		  • Number of counseling sessions / 1000 MCO enrollees who are Behavioral Health clients as defined in Exhibit G.

118	B1 c, d, e on Appendix K.	**Access: Wait Times**
		• Number of Days wait for initial appointment per 1. MCO Enrollees and 2) SMI, SED:
		  o Emergency
		  o Urgent
		  o Routine
		  o Total
		  • Number of crisis calls / 1000 MCO Enrollees
		  • Number of counseling sessions / 1000 MCO Enrollees
		  • Number of minutes to reach a clinician by telephone in 1)an emergency and 2) a non-emergency
		  • Number of days to reach a clinician by telephone (non-emergency)
		  • Prevention visits per 1000 MCO enrollees

118	B1 f, e (bullet 1, 2, 3, 4, 5) on Appendix K	**Outcomes for Medicaid Enrollees and for Chronic Cases (SMI, SED)** Details include the following each reported for two populations 1. Medicaid Enrollees and for 2. SMI,SED: • Number of psychiatric hospitalizations/1000 MCO Enrollees

		• Pharmaceutical expenditures/1000 MCO Enrollees
		• Number of Emergency Room visits/1000 MCO Enrollees
		• Percent adhering to recommended course of behavioral health treatment
		  o Adherence to Antipsychotics for Individuals with Schizophrenia
		  o Antidepressant Medication Management
		  o Annual Monitoring for Patients on Persistent Medications

119	B1 f, e (bullet 6) on Appendix K	**Behavioral Health Statistics Improvement Project Adult Survey** Details include the following each reported for two populations 1. Medicaid Enrollees and for 2. SMI • Percent of clients satisfied with access and quality of mental health services. Survey to be implemented by August 2012. Report due by Jan 1, 2013
120	B1 f, e (bullet 6) on Appendix K	**Behavioral Health Statistics Improvement Project Child Survey** Details include the following each reported for two populations 1. Medicaid Enrollees and for 2. SED • Percent of clients satisfied with access and quality of mental health services. Survey to be implemented by August 2012. Report due by Jan 1, 2013
118	B1 f, e (bullet 7, 8, 9) on Appendix K	**Outcomes for Medicaid Enrollees and for Chronic Cases (SMI, SED)** Details include the following each reported for two populations 1. Medicaid Enrollees and for 2. SMI,SED: • Percent maintaining employment or staying in school while in mental health treatment. • Percent with permanent housing while receiving mental health treatment • Percent arrested or incarcerated while receiving mental health treatment
118	B1 f, e (bullet 10) on Appendix K	**Outcomes for Medicaid Enrollees and for Chronic Cases (SMI, SED)** Details include the following each reported for two populations 1. Medicaid Enrollees and for 2. SMI,SED: • Health status - Definitions mimic HEDIS or AHRQ measures. for the four Behavioral Health Populations described in Exhibit G: • Number of Adult BMI, Height, and weight Assessments administered • Number of Nutritional Screening or Nutritional Counseling sessions • Number of session for Physical Activity Counseling • Number of sessions for medical assistance with smoking and Tobacco Use cessation.
97	Appendix L 97,	**Behavioral Health Services Adults and Children** Provide monthly and year-to-date reports of the unduplicated number and percentage of: • Total number of adults (age 18 and over) who are receiving behavioral health (mental health and substance abuse) Medicaid billable and non-Medicaid billable services • Total number of adults (age 18 and over) with SMI who are receiving behavioral health (mental health and substance abuse) Medicaid billable and non-Medicaid billable services, • Total number of adults and children/youth or their caregivers who received a Peer Support Service • Total number of children/youth i)under age 18 and ii)age 18-21, who are receiving behavioral health (mental health and substance abuse) Medicaid billable and non-

		Medicaid billable services, • Total number of youth & children under age 21 with SED who have received behavioral health (mental health or substance abuse) Medicaid billable and non-Medicaid billable services, • Total number of adults age 18 and over and children/youth under age 18 who have ever received *both* mental health *and* substance abuse Medicaid billable and non-Medicaid billable services; or have received integrated services (separating adults and children/youth). • Total number of Unduplicated Number of Children/Youth Receiving Impact Plus Prior Authorizations Each report should delineate by procedure code the number of unduplicated members receiving Medicaid billable and non-Medicaid billable services, the units of service and the total paid claims amount.
98	Appendix L, Report #115	**Behavioral Health Pregnant and Postpartum Women** The number and percentage of MCO Enrollees of pregnant and postpartum women with substance use disorders who received their first treatment visit within 48 hours of initial request for services.
118	Appendix L, Report #123	**Tobacco Product Users** The number of children/youth (less than age 18) and adults (18 and over) who report use (once a week or greater) of tobacco products (all types)
101	Appendix L, Report #113	**Trauma History Assessment:** The unduplicated number and percentage of MCO Enrollees of children/youth (age less than 18) who were assessed for trauma history.
101A	Appendix L, Report #120, 121, 122	**Behavioral Health and Chronic Physical Health** Details include the following each reported for the four Behavioral Health Populations in Exhibit G. • Total Unduplicated Number of Adults and Children/Youth with Behavioral Health Diagnosis's with PCP and Received Annual Wellness Check/Health Exam • Total Unduplicated Number of Adults and Children/Youth General Behavioral Health Diagnosis and Chronic Physical Health Diagnosis
103	Appendix L, Report #116	**Behavioral Health and PRTF/Residential and Inpatient Discharge** The number and percentage of children/youth (under age 21) and adults over age 18 who are discharged from an inpatient facility or PRTF who participate in an outpatient visit within seven (7) and fourteen (14) days.

118	Appendix L, Report #125	**Substance Use Disorder Screening**
		• Unduplicated number of adults (age 18+) who are screened for a substance use disorder in
		  ○ A. Emergency Room
		  ○ B. Primary Care Provider
		  ○ C. Specialized Care Provider
		  ○ D. Hospital Admission
		  ○ E. Other provider types
		• Unduplicated number of Children/Youth (age under 18) who are screened for a substance use disorder in
		  ○ A. Emergency Room
		  ○ B. Primary Care Provider
		  ○ C. Specialized Care Provider
		  ○ D. Hospital Admission
		  ○ E. Other provider types

Column Label	Description
NA	NA

Report #:	119	Created:	1/19/12
Name:	Behavioral Health Statistics Improvement Project Adult Survey	Last Revised:	
Group:	Mental Health and Substance Abuse	Report Status:	
Frequency:	Annual	Exhibits:	
Period:	Calendar Year: 01-JAN through 31-DEC		
Due Date:	31-AUG		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

Description:
The MCO shall conduct an annual survey of Behavioral Health Member satisfaction with services provided (client perception of care) . The behavioral health member satisfaction survey requirement shall be satisfied by the Contractor by administering the 28-Item Mental Health Statistics Improvement Program (MHSIP) Adult Survey plus additional 8 items for the Social Connectedness and Functioning National Outcome Measures (for adult behavioral health members). The MCO may contact the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to obtain a current version of the survey tools. Surveys should be administered by an NCQA certified survey vendor. The contractor shall submit a plan for administration (sampling strategy, survey methodology, etc.) to DBHDID prior to survey administration . DBHDID shall review and approve any Behavioral Health member survey instruments and plan for administration and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results in the format prescribed. Survey results shall include counts of Members surveyed by MCO Region and report percentages of Members who report positively about the following domains:
Adult Behavioral Health Members:

- Access
- Quality and Appropriateness
- Outcomes
- Treatment Planning
- General Satisfaction with Services

Sample Layout:

The Mental Health Statistics Improvement Program (MHSIP) Satisfaction Survey

MCO Region	Provider Type	Provider ID	Date Survey Completed	General Satisfaction	Access	Quality	Participation	Outcomes	Social Connectedness	Functioning

Domain Totals

								Outcomes	Social Connectedness	Functioning

Reporting Criteria:

The Mental Health Statistics Improvement Program (MHSIP) Satisfaction Survey

General Specifications	**Definition**
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
MCO Region	The Medical Region of the Provider location where the service was rendered. Report as a two character field. Valid values for services provided in Kentucky are 01 through 08. Services provided out of state are to be reported as 09.
Provider Type	All Provider Types billing for MH/SA procedure codes are to be listed. Billing Provider Type is designated with a state specific two (2) character field. Crosswalk of Provider type and Provider Specialty to each Provider Description if provided in Exhibit A: Provider Type and Specialty Crosswalk.
Provider ID	The Providers Medicaid ID
Date Survey Completed	The date in which the consumer completed the survey.
General Satisfaction	The Mean Score of the domain.
Access	The Mean Score of the domain.
Quality	The Mean Score of the domain.
Participation	The Mean Score of the domain.
Outcomes	The Mean Score of the domain.
Social Connectedness	The Mean Score of the domain.
Functioning	The Mean Score of the domain.

Report #:	120	Created:	1/19/12
Name:	Behavioral Health Statistics Improvement Project Child Survey	Last Revised:	
Group:	Mental Health and Substance Abuse	Report Status:	
Frequency:	Annual	Exhibits:	
Period:	Calendar Year: 01-JAN through 31-DEC		
Due Date:	31-AUG		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities		

Description:
The MCO shall conduct an annual survey of Behavioral Health Member satisfaction with services provided (client perception of care) . The behavioral health member satisfaction survey requirement shall be satisfied by the Contractor by administering the 21-Item Youth Services Survey Family Version (YSS-F) plus additional 4 items for the Social Connectedness National Outcome Measure (for parents /caregiver of child behavioral health members). The Contractor may contact the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to obtain a current version of the survey tools. Surveys should be administered by an NCQA certified survey vendor. The MCO shall submit a plan for administration (sampling strategy, survey methodology, etc.) to DBHDID prior to survey administration. DBHDID shall review and approve any Behavioral Health member survey instruments and plan for administration and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results in the format prescribed. Survey results shall include counts of Members surveyed by MCO Region and report percentages of Members who report positively about the following domains:
Child Behavioral Health Members:

- Access
- Outcomes
- Treatment Planning
- Family Members Reporting high Cultural Sensitivity of Staff
- General Satisfaction with Services

The Youth Services Survey for Families (YSS-F) Satisfaction Survey

Domain Totals

Reporting Criteria:
The Youth Services Survey for Families (YSS-F) Satisfaction Survey

General Specifications	**Definition**
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
MCO Region	The Medical Region of the Provider location where the service was rendered. Report as a two character field. Valid values for services provided in Kentucky are 01 through 08. Services provided out of state are to be reported as 09.

MCO Region	Provider Type	Provider ID	Date Survey Completed	General Satisfaction	Access	Cultural Sensitivity	Participation	Outcomes	Social Connectedness	Functioning

Provider Type	All Provider Types billing for MH/SA procedure codes are to be listed. Billing Provider Type is designated with a state specific two (2) character field. Crosswalk of Provider type and Provider Specialty to each Provider Description if provided in Exhibit A: Provider Type and Specialty Crosswalk.
Provider ID	The Providers Medicaid ID
Date Survey Completed	The date in which the consumer completed the survey.
General Satisfaction	The Mean Score of the domain.
Access	The Mean Score of the domain.
Cultural Sensitivity	The Mean Score of the domain.
Participation	The Mean Score of the domain.
Outcomes	The Mean Score of the domain.
Social Connectedness	The Mean Score of the domain.
Functioning	The Mean Score of the domain.

Report #:	126	Created:	08/28/2012
Name:	Federally Qualified Health Centers	Last Revised:	NA
Group:	Utliziation	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of the quarter through the last day of the quarter.		
Due Date:	45 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should provide a report on the total amount paid to each FQHC per month. Report will contain the following data elements:

- KY Medicaid ID
- Provider Name
- Number of Unduplicated claims excluding crossovers
- Total dollars paid for claims excluding crossovers
- Any TPL amount listed on the claim
- Number of unduplicated crossover claims
- Total dollars paid for crossover claims

Sample Layout:

To be defined.

Reporting Criteria:

To be defined.

Report #:	127	Created:	08/28/2012
Name:	Statement on Standards for Attestation Engagements (SSAE) No. 16	Last Revised:	NA

Group:	Audit/Internal Control	Report Status:	Active
Frequency:	Annual or as Apporpriate	Exhibits:	NA
Period:	As required by APA		
Due Date:	30 days following the first calendar quarter		
Submit To:	Kentucky Department for Medicaid Services		

Description:

MCO should provide the Statement on Standards for Attestation Engagements (SSAE) No. 16 Type II audit that addresses the engagements conducted by services providers on service organization for reporting design control and operational effectiveness.

Report #:	200	Created:	03/31/2012
Name:	Ineligible Assignment	Last Revised:	
Group:	HIPAA 834 Reconciliation Reports	Report Status:	Active
Frequency:	Daily (as needed)	Exhibits:	
Period:			
Due Date:	Daily based on processing of HIPAA 834 transactions.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

When the MCO identifies a Member that the MCO believes is not eligible for MCO enrollment the MCO shall identify the Member on the 'Ineligible Assignment' report.

When the potential ineligible member is identified through receipt of a HIPAA 834 transaction (daily or monthly) the MCO shall use the data received on the HIPAA 834 to complete the report. The MCO Comments field shall start with the date of the HIPAA 834 transaction.

When the potential ineligible member is identified through other means than the HIPAA 834 transaction the MCO shall complete the report using the active data from the MCO Eligibility system.

Sample Layout:

THIS SECTION TO BE COMPLETED BY THE MCO													TO BE COMPLETED BY DMS		
#	SSN	Medicaid ID	MCO Effective Date	MCO End Date	Date of Birth	Member Last Name	Member First Name	County	Program Code	Status Code	Institutional Status Code	MCO Comments	Action	Action Date	DMS Comments
1															
2															
3															

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy unless otherwise stated.

Row Label	Description
NA	NA

Column Label	Description
#	Counter to easily identify record.
SSN	Social Security Number of the Medicaid Member. To be reported as a 9 character text string without any dashes.
Medicaid ID	The Members Medicaid ID. To be reported as a text string.
MCO Effective Date	The Effective Date of the MCO assignment that the MCO believes to be invalid.
MCO End Date	The End Date of the MCO assignment that the MCO believes to be invalid.
Date of Birth	The Member's date of birth.
Member Last Name	The Member's last name.
Member First Name	The Member's first name.
County	The three digit county code of the Member to be reported as a 3 character text string.
Program Code	The Member's one or two character Program Code that corresponds to the assignment that the MCO believes to be invalid. To be reported as a text string.
Status Code	The Member's two character Status Code that corresponds to the assignment that the MCO believes to be invalid. To be reported as a text string.
Institutional Status Code	The Member's two character Institutional Status Code that corresponds to the assignment that the MCO believes to be invalid. To be reported as a text string.
MCO Comments	When the activity was identified through a HIPAA 834 transaction the HIPAA 834 transaction date is to be included as the first comment. Other comments may be included when the MCO believes it will assist the DMS in review of the report.
Action	The research results reported by DMS. Valid values and their description are: 1. MAC: MCO Assignment Correct No Action Taken 2. MIC: MCO Assignment Incorrect - Member Disenrolled
Action Date	The date the DMS reviewer reviewed and, if necessary, disenrolled the Member from the MCO. It is not the date of disenrollment. Rather it is the date that MCAPS and/or MMIS were updated with the disenrollment.
DMS Comments	Description of the reason why the 'Action' was taken.

Report #:	205	Created:	03/31/2012
Name:	Assignment Inquiry	Last Revised:	
Group:	HIPAA 834 Reconciliation Reports	Report Status:	Active
Frequency:	Daily (as needed)	Exhibits:	
Period:			
Due Date:	Daily based on processing of HIPAA 834 transactions.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

When the MCO identifies conflicting Member data elements the MCO shall identify the Member on the 'Assignment Inquiry' report.

When the conflicting data elements are identified though receipt of a HIPAA 834 transaction (daily or monthly) the MCO shall use the data received on the HIPAA 834 to complete the report. The MCO Comments field shall start with the date of the HIPAA 834 transaction.

When the conflicting data elements are identified through other means than the HIPAA 834 transaction the MCO shall complete the report using the active data from the MCO Eligibility System.

Sample Layout:

THIS SECTION TO BE COMPLETED BY THE MCO										TO BE COMPLETED BY DMS		
#	SSN	Medicaid ID	MCO Effective Date	MCO End Date	Data Element #1	Data Element #2	Data Element #3	Data Element #4	MCO Comments	Action	Action Date	DMS Comments
1												
2												
3												

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy unless otherwise stated.

Row Label	Description
NA	NA

Column Label	Description
#	Counter to easily identify record.
SSN	Social Security Number of the Medicaid Member. To be reported as a 9 character text string without any dashes.
Medicaid ID	The Members Medicaid ID. To be reported as a text string.
MCO Effective Date	The Effective Date of the MCO assignment that the MCO believes to be invalid.
MCO End Date	The End Date of the MCO assignment that the MCO believes to be invalid.
Data Element #1	Member information that may conflict with other reported Member information. For example: If a Program Code does not match a Foster Care indicator then the Program Code value should be populated.
Data Element #2	Member information that may conflict with other reported Member information. To follow the example from Data Element #1: If a Program Code does not match a Foster Care indicator then the Foster Care Indicator should be populated.
Data Element #3	Member information that may conflict with other reported Member information.
Data Element #4	Member information that may conflict with other reported Member information.
MCO Comments	When the activity was identified through a HIPAA 834 transaction the HIPAA 834 transaction date is to be included as the first comment. Other

	comments may be included when the MCO believes it will assist the DMS in review of the report.
Action	The research results reported by DMS.
Action Date	The date the DMS reviewer reviewed and, if necessary, modified the Member's information.
DMS Comments	Description of the reason why the 'Action' was taken.

Report #:	210	Created:	03/31/2012
Name:	Duplicate Member	Last Revised:	
Group:	HIPAA 834 Reconciliation Reports	Report Status:	Active
Frequency:	Daily (as needed)	Exhibits:	
Period:			
Due Date:	Daily based on processing of HIPAA 834 transactions.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

When the MCO identifies a potential duplicate Member assignment the MCO shall identify the Member on the 'Duplicate Member' report.

When the potential duplicate Member is identified though receipt of a HIPAA 834 transaction (daily or monthly) the MCO shall use the data received on the HIPAA 834 to complete the report. The MCO Comments field shall start with the date of the HIPAA 834 transaction.

When the potential duplicate Member is identified through other means than the HIPAA 834 transaction the MCO shall complete the report using the active data from the MCO Eligibility System.

The MCO may include in the MCO Comment field details as to why the MCO believes the Member is a duplicate if the MCO deems the information critical for DMS review.

Sample Layout:

	Member Existing on MCO System					Member Received on HIPAA 834 Transaction or Member Existing on MCO System						TO BE COMPLETED BY DMS		
#	Member Last Name	Member First Name	Date of Birth	SSN	Medicaid ID	Member Last Name	Member First Name	Date of Birth	SSN	Medicaid ID	MCO Comments	Action	Action Date	DMS Comments
1														
2														
3														

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy unless otherwise stated.

Row Label	Description
NA	NA

Column Label	Description
#	Counter to easily identify record.
Member Existing on MCO System	Information reported is to be based on the Member's information that the MCO already had loaded from a previous HIPAA 834 transaction.
Member Received on HIPAA 834 Transaction or Member Existing on MCO System	Information reported is to be based on the Member's information received on the most recent HIPAA 834 transaction or the MCO's Member system if the duplicate is identified from a source other than a HIPAA 834.
Member Last Name	The Member's last name.
Member First Name	The Member's first name.
Date of Birth	The Member's date of birth.
SSN	Social Security Number of the Medicaid Member. To be reported as a 9 character text string without any dashes.
Medicaid ID	The Members Medicaid ID. To be reported as a text string.
MCO Comments	When the activity was identified through a HIPAA 834 transaction the HIPAA 834 transaction date is to be included as the first comment. Other comments may be included when the MCO believes it will assist the DMS in review of the report.
Action	The research results reported by DMS. Valid values and their description are: 1. Duplicate/Linked: Members were determined to be duplicative and were linked. 2. Not Duplicate: Members are not duplicate and no additional action was taken.
Action Date	The date the DMS reviewer reviewed and, if necessary, linked the Member IDs in the MMIS.
DMS Comments	Description of the reason why the 'Action' was taken. For Member IDs that are linked the ID that remains active and the ID that is inactivated will be identified.

Report #:	220	Created:	03/31/2012
Name:	Newborn	Last Revised:	
Group:	HIPAA 834 Reconciliation Reports	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:			
Due Date:	15th of the Month		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO shall submit the 'Newborn' report (MCO Report # 220) monthly for all newborns that are thirty (30) days or older for which the MCO has not received a HIPAA 834 enrollment transaction.

Sample Layout:

	THIS SECTION TO BE COMPLETED BY THE MCO									TO BE COMPLETED BY DMS				
#	Newborn Last Name	Newborn First Name	Date of Birth	Gender	Newborn County	Mother's Member Number or SSN	Mother's Last Name	Mother's First Name	Days Old	Action	Action Date	30 Day Action	30 Day Action Date	Comments

1														
2														
3														
4														

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy unless otherwise stated.

Row Label	Description
NA	NA

Column Label	Description
#	Counter to easily identify record.
Newborn Last Name	The Newborn's last name.
Newborn First Name	The Newborn's first name.
Date of Birth	The Newborn's date of birth.
Gender	The Newborn's gender.
Newborn County	The three digit county code of the Newborn to be reported as a 3 character text string.
Mother's Member Number or SSN	Provide Newborn Mother's Medicaid ID or Social Security Number associated with the mother's enrollment information from the state system. Medicaid ID to be reported as a text string. SSN to be reported as a 9 character text string without any dashes.
Mother's Last Name	Provide Newborn's Mother last name if available at time of the report associated with the mother's enrollment information from the state system.
Mother's First Name	Provide Newborn's Mother first name if available at time of the report associated with the mother's enrollment information from the state system.
Days Old	Provide Newborn's age as number of days old. The Newborn on their date of birth is to be counted as one (1) day old.
Action	The research results reported by DMS. Valid values and their description are: NNE: The Newborn is not enrolled in Medicaid. Enrollment process has been initiated. NE not MCO: The Newborn is enrolled in Medicaid but is not eligible for enrollment in the MCO. NE MCO: The Newborn is enrolled in Medicaid and is enrolled with the MCO. NE add MCO The Newborn is enrolled in Medicaid and has now been assigned to the MCO.
Action Date	The date the DMS reviewer initially reviewed the Newborns Medicaid

	eligibility and, if necessary, assigned the Newborn to the MCO. It is not the date of enrollment. Rather it is the date that MCAPS and/or MMIS were updated with the assignment.
30 Day Action	For 'Action' values of NNE, DMS will update the status of the Newborn Medicaid enrollment. Valid values and their description of that action are: NE and MCO: The Newborn was enrolled in Medicaid and assigned to the MCO. NE not MCO: The Newborn was enrolled in Medicaid but was not assigned to the MCO. NNE: The Newborn was not enrolled in Medicaid.
30 Day Action Date	The date the DMS reviewer updated the Newborn Medicaid Enrollment and, if necessary, assigned the Newborn to the MCO. It is not the date of enrollment. Rather it is the date that MCAPS and/or MMIS were updated with the assignment.
Comments	Description of the reason why the 'Action' and/or '30 Day Action' was taken. The Newborn Medicaid Id will be provided For Newborns enrolled in Medicaid that are assigned to the MCO ('30 Day Action' value of NE and MCO).

Report #:	230	Created:	03/31/2012
Name:	Capitation Payment Request	Last Revised:	
Group:	HIPAA 820 Reconciliation Reports	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:	Months prior to or equal to the MMIS Reconciliation Month		
Due Date:	45 Days after receipt of the HIPAA 820 containing the MMIS Reconciliation Month		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO shall submit the 'Capitation Payment Request' report of all members that the MCO identifies for which payment has not been received. Only those months equal to or prior to the MMIS Managed Care Reconciliation Month (MMIS Recon Month) are to be reported.

Sample Layout:

	THIS SECTION TO BE COMPLETED BY THE MCO										TO BE COMPLETED BY DMS				
#	Capitation Month	Medicaid ID	Effective Date	End Date	Region	County	Program Code	Status Code	Age	MCO Comments	Member MCO Eligible	Date Eligibility Reviewed	Cap Created	Cap Created Date	DMS Comments
1															
2															
3															

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy unless otherwise stated.

Row Label	Description
NA	NA

Column Label	Description
#	Counter to easily identify record.
Capitation Month	The Month that the MCO did not receive a payment for the Member. To be formatted as <yyyy/mm>.
Medicaid ID	The Members Medicaid ID. To be reported as a text string.
Effective Date	The Effective Date of the MCO assignment.
End Date	The End Date of the MCO assignment.
Region	The Member two (2) digit Region based on the Member's County. To be reported as a text string.
County	The three digit county code to be reported as a 3 character text string.
Program Code	The Member's one or two character Program Code that corresponds to the MCO assignment for the 'Capitation Month'. To be reported as a text string.
Status Code	The Member's two character Status Code that corresponds to the MCO assignment for the 'Capitation Month'. To be reported as a text string.
Age	The age that the Member would have attained as of the end of the 'Capitation Month'.
MCO Comments	Comments may be included when the MCO believes it will assist the DMS in review of the report.
Member MCO Eligible	Based on review of the Member's Medicaid and MCO eligibility, the DMS reviewer will indicate if the Member was eligible to receive a capitation payment for the 'Capitation Month'. Valid values are Y and N.
Date Eligibility Reviewed	The date the 'Member MCO Eligible' determination was made.
Cap Created	An indicator (Y or N) identifying if a capitation payment record was created in the MMIS.
Cap Created Date	The date the capitation payment record was created in the MMIS.
DMS Comments	Description of the reason why the 'Member MCO Eligible' and/or 'Cap Created' indicators were set.

Report #:	240	Created:	03/31/2012
Name:	Capitation Duplicate Payment	Last Revised:	
Group:	HIPAA 820 Reconciliation Reports	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:	Months prior to or equal to the MMIS Reconciliation Month		
Due Date:	45 Days after receipt of the HIPAA 820 containing the MMIS Reconciliation Month		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO shall submit the 'Capitation Duplicate Payment' report for Members that the MCO identifies as having

received duplicate payments. Only those months equal to or prior to the MMIS Recon Month are to be reported.

Sample Layout:

		Capitation Payment # 1			Capitation Payment # 2			Capitation Payment # 3				TO BE COMPLETED BY DMS				
#	Capitation Month	Medicaid ID	Payment Amount	Payment Date	Medicaid ID	Payment Amount	Payment Date	Medicaid ID	Payment Amount	Payment Date	MCO Comments	Member MCO Eligible	Date Eligibility Reviewed	Cap Recoup Created	Cap Created Date	DMS Comments
1																
2																
3																

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy unless otherwise stated.

Row Label	Description
NA	NA

Column Label	Description
#	Counter to easily identify record.
Capitation Month	The Month that the MCO received a duplicate payment for the Member. To be formatted as <yyyy/mm>.
Medicaid ID	The Members Medicaid ID. To be reported as a text string.
Payment Amount	The amount of the capitation payment that the MCO received.
Payment Date	The date that the capitation payment was paid.
MCO Comments	Comments may be included when the MCO believes it will assist the DMS in review of the report.
Member MCO Eligible	Based on review of the Member's Medicaid and MCO eligibility, the DMS reviewer will indicate if the Member was eligible to receive a capitation payment for the 'Capitation Month'. Valid values are Y and N.
Date Eligibility Reviewed	The date the 'Member Eligible' determination was made.
Cap Recoup Created	An indicator (Y or N) identifying if a capitation recoupment record was created in the MMIS.
Cap Created Date	The date the capitation recoupment record was created in the MMIS.
DMS Comments	Description of the reason why the 'Member MCO Eligible' and/or 'Cap Recoup Created' indicators were set.

Report #:	250	Created:	03/31/2012
Name:	Capitation Adjustments Request	Last Revised:	
Group:	HIPAA 834 Reconciliation Reports	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:	Months prior to or equal to the MMIS Reconciliation Month		
Due Date:	45 Days after receipt of the HIPAA 820 containing the MMIS Reconciliation Month		

Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO shall submit the 'Capitation Adjustment Requests' report for Members that the MCO believes an inaccurate capitation payment was made. The capitation adjustment requests are limited to the capitation payments made for the MMIS Recon Month or capitation payments that were made as retroactive payments that will not be adjusted though the MMIS Recon processes because the capitation month is prior to the MMIS Recon Month.

Sample Layout:

		Capitation Payment Received							Capitation Payment Expected			
#	Type of Adjustment	Capitation Month	Medicaid ID	Program Code	Status Code	County	Payment Amount	Payment Date	Program Code	Status Code	County	Payment Amount
1												
2												
3												
4												

TO BE COMPLETED BY DMS				
Member MCO Eligible	Date Eligibility Reviewed	Cap Adjust Created	Cap Adjust Date	Comments

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy unless otherwise stated.

Row Label	Description
NA	NA

Column Label	Description
#	Counter to easily identify record.
Type of Adjustment	The description of the type of payment that the MCO believes is not correct. Valid values are: 1. Overpayment: MCO believes the capitation payment received was too high because the Member qualifies under a different Category of Aid and/or resides in a different Region. 2. Underpayment: MCO believes the capitation payment received was to low because the member qualifies under a different Category of Aid and/or resides in a different Region. 3. Prorate: MCO believes the capitation payment received was incorrectly prorated based on the Member's Effective date and/or Category of Aid.
Capitation Month	The Month that the MCO received a payment for the Member. To be formatted as <yyyy/mm>.

Medicaid ID	The Members Medicaid ID. To be reported as a text string.
<Capitation Payment Received> Program Code	The Member's one or two character Program Code that corresponds to the Member's capitation payment received. To be reported as a text string.
<Capitation Payment Received> Status Code	The Member's two character Status Code that corresponds to the Member's capitation payment received. To be reported as a text string.
<Capitation Payment Received> County	The three digit county code of the Member that corresponds to the Member's capitation payment received. To be reported as a 3 character text string.
<Capitation Payment Received> Payment Amount	The capitation payment amount received.
Payment Date	The date of payment for the capitation payment amount received.
<Capitation Payment Expected> Program Code	The Member's one or two character Program Code that corresponds to the Member's eligibility that the MCO believes should have been paid. To be reported as a text string.
<Capitation Payment Expected> Status Code	The Member's two character Status Code that corresponds to the Member's eligibility that the MCO believes should have been paid. To be reported as a text string.
<Capitation Payment Expected> County	The three digit county code of the Member that corresponds to the Member's eligibility that the MCO believes should have been paid. To be reported as a 3 character text string.
<Capitation Payment Expected> Payment Amount	The capitation payment amount expected by the MCO.
Member MCO Eligible	Based on review of the Member's Medicaid and MCO eligibility, the DMS reviewer will indicate if the Member was eligible to receive a capitation adjustment payment for the 'Capitation Month'. Valid values are: 1. Y: Capitation payment should have been made as the MCO expected. 2. N: Capitation payment received by the MCO was correct and no adjustment is to be made. 3. O: Capitation payment received by the MCO and the capitation payment expected by the MCO are not correct. Other capitation adjustment is warranted.
Date Eligibility Reviewed	The date the 'Member MCO Eligible' determination was made.
Cap Adjust Created	When the 'Member MCO Eligible' is Y or O then a capitation adjustment will be created. A recoupment of the existing payment record will be created and a new record for the correct capitation payment will be created. Valid values and their description are: 1. Y: Recoupment and payout adjustments were created in the MMIS. 2. R: Recoupment adjustment created only. Will occur if the Member was determined not to be MCO eligible for the capitation month. 3. N: Capitation adjustments records were not created. Will occur if the adjustment request does not qualify based on the capitation month and/or capitation adjustment not eligible for reconciliation.
Cap Adjust Date	The date the 'Cap Adjust Created' review/action was taken.
Comments	Description of the reason why actions were taken as they relate to either Member eligibility/enrollment with MCO and capitation adjustments.

Report #:	260	Created:	03/31/2012
Name:	MCO Claims Paid for Voided Members	Last Revised:	

Group:	HIPAA 834 Reconciliation Reports	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:	Months prior to or equal to the MMIS Reconciliation Month		
Due Date:	45 Days after receipt of the HIPAA 820 containing the MMIS Reconciliation Month		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The MCO may submit the 'MCO Claims Paid for Voided Members' report for claims paid for a Member whose enrollment was subsequently voided. Only claims paid with dates-of service during or prior to the MMIS Recon Month are to be reported.

Sample Layout:

#	HIPAA 834 Transaction Assignment Date	HIPAA 834 Transaction Disenrollment Date	Medicaid ID	MCO ICN	Claim Detail Number	MCO Paid Date	Billing Provider Medicaid ID	Category of Service	First Date of Service	Units Allowed	Paid Amount	Medicaid ICN
1												
2												
3												

TO BE COMPLETED BY DMS							
Claim DOS and MCO Assignment Verified	Member Current MCO Assignment	Date Eligibility Reviewed	Paid Claim for Medicaid MCO Covered Service	MCO Reported Medicaid ICN Correct	Cap Adjust Created	Cap Adjust Date	Comments

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy unless otherwise stated.

Row Label	Description
NA	NA

Column Label	Description
#	Counter to easily identify record.
HIPAA 834 Transaction Assignment Date	The date of the HIPAA 834 transaction that the MCO received the Member assignment.
HIPAA 834 Transaction Disenrollment Date	The date of the HIPAA 834 transaction that the MCO received the Member Void/Term.
Medicaid ID	The Members Medicaid ID. To be reported as a text string.
MCO ICN	The MCO unique identifier for the Claim.
Claim Detail Number	The line item of the claim that was paid and for which reimbursement is

	requested.
MCO Paid Date	The date the MCO paid the claim.
Billing Provider Medicaid ID	The Medicaid ID of the Billing Provider. To be reported as a text string.
Category of Service	The state two character code representative of the service provided.
First Date of Service	The first date of service on the claim whne the Member received the service provided.
Units Allowed	The number of units that the MCO allowed to be provided.
Paid Amount	The MCO paid amount.
Medicaid ICN	If the MCO has a Medicaid ICN for an encounter that was submitted to and accepted by the MMIS then the MCO is to include the Medicaid ICN.
Claim DOS and MCO Assignment Verified	DMS verification that the date-of-service on the claim was during a period of time that the Member was assigned to an MCO prior to the Member Void/Term from the MCO. Valid values are "Y" when the date-of-service on the claim matches the Member's MCO assignment and "N" when the date-of-service on the claim does not match the Member's MCO assignment.
Member Current MCO Assignment	DMS to verify and identify if the Member was assigned to another MCO or to Medicaid for the date-of-service on the claim. MCO Name or FFS is to be populated.
Date Eligibility Reviewed	The date DMS eligibility review was completed.
Paid Claim for Medicaid MCO Covered Service	DMS verification that the claim paid by the MCO was for a Medicaid Managed Care covered service. Valid values are "Y" when the service is Medicaid Managed Care covered and "N" when the service is not Medicaid Managed Care covered.
MCO Reported Medicaid ICN Correct	DMS verification that the Medicaid ICN reported by the MCO is correct. Valid values are "Y" when the ICN is correct and "N" when the ICN is not correct. DMS will also check to verify if the encounter was subsequently submitted and if so populate the Medicaid ICN.
Cap Adjust Created	DMS to verify that capitation payment was adjusted correctly. If a recoupment of a capitation is required DMS will create a capitation recoupment record. Valid values are "N" when capitation adjustments are correct and no additional adjustment was needed and "Y" when a capitation adjustment is necessary and was created.
Cap Adjust Date	The date a capitation recoupment record was created.
Comments	Description of the reason why actions were taken as they relate to either Member eligibility/enrollment with MCO and capitation adjustments.

EXHIBITS

Exhibit:	A	Created:	08/19/2011
Name:	Billing Provider Type and Specialty Crosswalk	Last Revised:	10/12/2011
Reports:	28, 58, 59, 60, 61, 62, 63		

The following crosswalk is based on Kentucky's department for Medicaid Services Fee for Service and Capitation programs. Not all of the listed Billing Provider Types will be reported by the MCOs since the MCOs are not responsible for all Medicaid services.

Billing Provider Type	Billing Provider Specialty	Billing Provider Description/Category
01	010	General Hospital - Inpatient Hospital
01	012	General Hospital - Inpatient Hospital
01	014	General Hospital - Inpatient Hospital
01	015	General Hospital - Inpatient Hospital
01	016	General Hospital - Inpatient Hospital
01	017	General Hospital - Inpatient Hospital
02	011	Mental Hospital
39	300	Renal Dialysis
41	411	Model Waiver 1
41	412	Model Waiver 2
04	013	Psychiatric Residential Treatment Facilities (PRTF)
01	010	General Hospital - Outpatient Hospital
01	012	General Hospital - Outpatient Hospital
01	014	General Hospital - Outpatient Hospital
01	015	General Hospital - Outpatient Hospital
01	016	General Hospital - Outpatient Hospital
01	017	General Hospital - Outpatient Hospital
36	020	Ambulatory Surgical
15	151	HANDS
29	291	Impact Plus
29	292	Impact Plus
29	299	Impact Plus
13	131	Specialized Children's Services Clinics
13	088	Specialized Children's Services Clinics
27	222	Targeted Case Mgmt. - Mentally Ill Adults
27	223	Targeted Case Mgmt. - Mentally Ill Adults
27	224	Targeted Case Mgmt. - Mentally Ill Adults
28	225	Targeted Case Mgmt. - Emotionally Disturbed Child
28	226	Targeted Case Mgmt. - Emotionally Disturbed Child
28	227	Targeted Case Mgmt. - Emotionally Disturbed Child
23	239	Title V/DSS
21	120	School-Based Services
22	229	Children with Special Health Care Needs
11	030	ICF - General
11	031	ICF-MR
11	032	ICF-MR
11	033	ICF-MR

11	034	ICF-MR
11	036	ICF-MR
11	037	ICF-MR
12	017	Nursing Facilities
12	031	Nursing Facilities
12	032	Nursing Facilities
12	179	Nursing Facilities
12	030	Nursing Facilities
25	221	Targeted Case Management
25	211	Targeted Case Management
25	214	Targeted Case Management
25	215	Targeted Case Management
25	216	Targeted Case Management
25	222	Targeted Case Management
25	223	Targeted Case Management
25	224	Targeted Case Management
25	226	Targeted Case Management
25	227	Targeted Case Management
20	201	Preventive
24	249	Early Intervention - First Steps
45	455	EPSDT - Related
45	558	EPSDT - Related
45	039	EPSDT - Related
45	412	EPSDT - Related
45	550	EPSDT - Related
45	551	EPSDT - Related
45	552	EPSDT - Related
45	553	EPSDT - Related
45	554	EPSDT - Related
45	555	EPSDT - Related
45	556	EPSDT - Related
45	557	EPSDT - Related
45	559	EPSDT - Related
45	560	EPSDT - Related
45	563	EPSDT - Related
45	564	EPSDT - Related
45	565	EPSDT - Related
45	567	EPSDT - Related
45	568	EPSDT - Related
45	569	EPSDT - Related
45	570	EPSDT - Related

45	571	EPSDT - Related
45	573	EPSDT - Related
45	574	EPSDT - Related
45	575	EPSDT - Related
45	576	EPSDT - Related
45	577	EPSDT - Related
45	578	EPSDT - Related
45	579	EPSDT - Related
45	580	EPSDT - Related
45	150	EPSDT - Related
45	999	EPSDT - Related
11	035	Skilled Nursing Home - General
82	116	Clinical Social Worker
82	115	Clinical Social Worker
82	829	Clinical Social Worker
85	150	Chiropractor
85	859	Chiropractor
86	861	Other Lab/X-Ray
38	861	Other Lab/X-Ray
86	251	Other Lab/X-Ray
86	542	Other Lab/X-Ray
87	170	Physical Therapist
87	879	Physical Therapist
88	171	Occupational Therapist
88	889	Occupational Therapist
89	112	Psychologist
89	899	Psychologist
90	250	Durable Medical Equipment (DME)
90	277	Durable Medical Equipment (DME)
31	080	Primary Care (FQHC)
31	082	Primary Care (FQHC)
31	000	Primary Care (FQHC)
30	111	Community Mental Health Centers
30	110	Community Mental Health Centers
30	114	Community Mental Health Centers
30	118	Community Mental Health Centers
35	081	Rural Health
35	000	Rural Health
72	729	Nurse Midwife
72	095	Nurse Midwife
32	083	Family Planning - Clinic

34	050	Home Health
34	051	Home Health
34	210	Home Health
34	211	Home Health
37	280	Laboratories
37	281	Laboratories
40	183	EPSDT - Screens
71	000	Birthing Centers
33	039	Supports for Community Living (SCL)(Formerly AIS/MR)
42	561	Home & Community Based Services
43	410	Adult Day Care
74	094	Nurse Anesthetist
74	749	Nurse Anesthetist
44	060	Hospice
46	080	Home Care Waiver
46	461	Home Care Waiver
46	462	Home Care Waiver
46	463	Home Care Waiver
46	464	Home Care Waiver
46	466	Home Care Waiver
46	465	Home Care Waiver
47	080	Personal Care Waiver
47	461	Personal Care Waiver
47	470	Personal Care Waiver
47	473	Personal Care Waiver
47	471	Personal Care Waiver
47	472	Personal Care Waiver
17	179	Brain Injury
55	261	Ambulance
55	260	Ambulance
57	671	Non-Emergency Transportation
56	261	Non-Emergency Transportation
56	262	Non-Emergency Transportation
56	263	Non-Emergency Transportation
56	264	Non-Emergency Transportation
56	265	Non-Emergency Transportation
56	266	Non-Emergency Transportation
56	267	Non-Emergency Transportation
56	661	Non-Emergency Transportation
54	240	Pharmacy
54	000	Pharmacy

14	000	MFP Transition
17	000	MFP Post-Transition
33	000	MFP Post-Transition
41	000	MFP Post-Transition
42	000	MFP Post-Transition
43	000	MFP Post-Transition
52	000	Optometry
77	000	Optometry
52	180	Optometry
52	190	Optometry
52	528	Optometry
77	180	Optometry
77	779	Optometry
60	271	Dental
60	272	Dental
60	273	Dental
60	274	Dental
60	277	Dental
61	271	Dental
61	272	Dental
61	273	Dental
61	274	Dental
61	277	Dental
61	610	Dental
60	270	Dental
60	275	Dental
60	276	Dental
61	270	Dental
61	275	Dental
61	276	Dental
65	313	Physicians
65	315	Physicians
65	316	Physicians
65	317	Physicians
65	319	Physicians
65	320	Physicians
65	323	Physicians
65	327	Physicians
65	334	Physicians
65	335	Physicians
65	338	Physicians

65	340	Physicians
65	344	Physicians
65	346	Physicians
65	347	Physicians
65	348	Physicians
64	112	Physicians
64	272	Physicians
64	310	Physicians
64	311	Physicians
64	312	Physicians
64	314	Physicians
64	318	Physicians
64	321	Physicians
64	322	Physicians
64	324	Physicians
64	325	Physicians
64	326	Physicians
64	327	Physicians
64	328	Physicians
64	330	Physicians
64	331	Physicians
64	332	Physicians
64	333	Physicians
64	336	Physicians
64	337	Physicians
64	338	Physicians
64	339	Physicians
64	341	Physicians
64	342	Physicians
64	343	Physicians
64	345	Physicians
65	272	Physicians
65	293	Physicians
65	310	Physicians
65	311	Physicians
65	312	Physicians
65	314	Physicians
65	318	Physicians
65	321	Physicians
65	322	Physicians
65	324	Physicians

65	325	Physicians
65	326	Physicians
65	328	Physicians
65	330	Physicians
65	331	Physicians
65	332	Physicians
65	333	Physicians
65	336	Physicians
65	337	Physicians
65	339	Physicians
65	341	Physicians
65	342	Physicians
65	343	Physicians
65	345	Physicians
65	650	Physicians
64	000	Physicians
65	000	Physicians
64	313	Physicians
64	315	Physicians
64	316	Physicians
64	317	Physicians
64	319	Physicians
64	320	Physicians
64	323	Physicians
64	334	Physicians
64	335	Physicians
64	340	Physicians
64	344	Physicians
64	346	Physicians
64	347	Physicians
64	348	Physicians
64	329	Physicians
65	329	Physicians
64	543	Physicians
78	090	Nurse Practitioner/Midwife
78	091	Nurse Practitioner/Midwife
78	092	Nurse Practitioner/Midwife
78	093	Nurse Practitioner/Midwife
78	095	Nurse Practitioner/Midwife
78	789	Nurse Practitioner/Midwife
78	000	Nurse Practitioner/Midwife

50	220	Hearing
70	200	Hearing
50	509	Hearing
70	709	Hearing
80	140	Podiatry
80	809	Podiatry
91	911	Comp. Outpatient Rehab. Facility
91	912	Comp. Outpatient Rehab. Facility
92	011	Psych Distinct Part Unit
93	040	Rehab Distinct Part Unit
93	012	Rehab Distinct Part Unit
95	100	Physician Assistant
95	959	Physician Assistant
95	101	Physician Assistant
96	071	Managed Care - Physical Health
96	072	Managed Care - Physical Health
97	000	Managed Care - Behavioral Health

Exhibit:	B	Created:	08/19/2011
Name:	Billing Provider Type Category Crosswalk	Last Revised:	10/12/2011
Reports:	28, 58, 59, 60, 61, 62, 63		

Terminology	Definition
Rx	Rx is an abbreviation for Pharmacy
BH	BH is an abbreviation for Behavioral Health

Billing Provider Type	Description	Category	Criteria to Determine Category
01	General Hospital	Inpatient	Bill Type = 11x, 12x, 21x or 22x
01	General Hospital	Outpatient	Bill Type = 13x
01	General Hospital	Emergency Room	Revenue Code = 450, 451, 452 or 459
01	General Hospital	Inpatient/Outpatient Other	All other Inpatient/Outpatient Hospital Claims
54	Pharmacy	Rx non-BH Brand	Brand National Drug Code from 2009 Red Book
54	Pharmacy	Rx non-BH Generic	Generic NDC from 2009 Red Book
54	Pharmacy	Rx BH Brand	Therapeutic class description for behavioral health 61and brand NDC from 2009 Red Book
54	Pharmacy	Rx BH Generic	Therapeutic class description for behavioral health and generic NDC from 2009 Red Book

Exhibit:	C	Created:	08/21/2011
Name:	Provider Enrollment Activity Reasons	Last Revised:	10/01/2011
Reports:	69, 70		

General Specifications	Definition
Denial	Applies when an MCO non-participating Provider or Subcontractor is denied participation with an MCO.
Termination	Applies when an MCO's current participating Provider or Subcontractor is suspended or terminated from participation with an MCO.

Type of Reason	Reason Code	Reason Code Description
Denial or Termination	B	Medicare Action
Denial or Termination	C	License Revoked
Denial or Termination	D	License Expired
Termination	E	Voluntary Termination
Termination	F	Retired
Termination	G	Deceased
Termination	I	Inactive for Two or more Years
Denial or Termination	K	Awaiting Re-credentialing
Denial or Termination	L	License Suspended
Denial or Termination	M	License Surrender
Denial or Termination	O	No ADO
Denial or Termination	T	Medicaid Action
Termination	X	MCO Rebid (subcontractor only)
Termination	Y	MCO Action (subcontractor only)

Exhibit:	D	Created:	09/07/2011
Name:	Category of Service Crosswalk	Last Revised:	09/07/2011
Reports:	28, 78		

Category of Service is primarily based on the Billing Provider Type and Billing Provider Specialty with the following additional criteria:

1. Provider Type 01 (General Hospital) is applicable to Category of Services 02-Inpatient and 12-Outpatient. Type of Bill should be used to identify Inpatient versus Outpatient.
2. EPSDT services are defined below and in Exhibit E.

For Claims that pay at the Line item, Category of Service is defined at the Line Item level.

EPSDT services are to be determined as follows:

1. Verify Member Age <= 20 prior to any other checks for EPSDT.
2. Claims submitted by Billing Provider Type 45 are to be assigned Category of Service 32 as defined on the crosswalk.
3. Exhibit E identifies how to handle other Billing Provider Types based on diagnosis and HCPC procedure codes.

The Category of Service listing provided is based on Medicaid's FFS and Capitation program. Since MCOs are not responsible for all Medicaid services, not all of the Category of Services will be reported by the MCOs.

Billing Provider Type	Billing Provider Specialty	Category of Service	Category of Service Description	EPSDT Comment
01	010	02	Inpatient Hospital	#N/A
01	012	02	Inpatient Hospital	#N/A
01	014	02	Inpatient Hospital	#N/A
01	015	02	Inpatient Hospital	#N/A
01	016	02	Inpatient Hospital	#N/A
01	017	02	Inpatient Hospital	#N/A
02	011	03	Mental Hospital	#N/A
39	300	04	Renal Dialysis	#N/A
41	411	05	Model Waiver 1	#N/A
41	412	07	Model Waiver 2	#N/A
04	013	08	Psychiatric Residential Treatment Facilities (PRTF)	#N/A
01	010	12	Outpatient Hospital	#N/A
01	012	12	Outpatient Hospital	#N/A
01	014	12	Outpatient Hospital	#N/A
01	015	12	Outpatient Hospital	#N/A
01	016	12	Outpatient Hospital	#N/A
01	017	12	Outpatient Hospital	#N/A
36	020	13	Ambulatory Surgical	#N/A
15	151	15	HANDS	#N/A
29	291	16	Impact Plus	#N/A
29	292	16	Impact Plus	#N/A
29	299	16	Impact Plus	#N/A
13	131	17	Specialized Children's Services Clinics	#N/A
13	088	17	Specialized Children's Services Clinics	#N/A
27	222	20	Targeted Case Mgmt. - Mentally Ill Adults	#N/A
27	223	20	Targeted Case Mgmt. - Mentally Ill Adults	#N/A
27	224	20	Targeted Case Mgmt. - Mentally Ill Adults	#N/A
28	225	21	Targeted Case Mgmt. - Emotionally Disturbed Child	#N/A
28	226	21	Targeted Case Mgmt. - Emotionally Disturbed Child	#N/A
28	227	21	Targeted Case Mgmt. - Emotionally Disturbed Child	#N/A
23	239	22	Title V/DSS	#N/A
21	120	23	School-Based Services	#N/A
22	229	24	Children with Special Health Care Needs	#N/A
11	030	25	ICF - General	#N/A
11	031	26	ICF-MR	#N/A
11	032	26	ICF-MR	#N/A
11	033	26	ICF-MR	#N/A
11	034	26	ICF-MR	#N/A

11	036	26	ICF-MR	#N/A
11	037	26	ICF-MR	#N/A
12	017	27	Nursing Facilities	#N/A
12	031	27	Nursing Facilities	#N/A
12	032	27	Nursing Facilities	#N/A
12	179	27	Nursing Facilities	#N/A
12	030	27	Nursing Facilities	#N/A
25	221	28	Targeted Case Management	#N/A
25	211	28	Targeted Case Management	#N/A
25	214	28	Targeted Case Management	#N/A
25	215	28	Targeted Case Management	#N/A
25	216	28	Targeted Case Management	#N/A
25	222	28	Targeted Case Management	#N/A
25	223	28	Targeted Case Management	#N/A
25	224	28	Targeted Case Management	#N/A
25	226	28	Targeted Case Management	#N/A
25	227	28	Targeted Case Management	#N/A
20	201	29	Preventive	Check for EPSDT Service
24	249	30	Early Intervention - First Steps	#N/A
45	455	32	EPSDT - Related	#N/A
45	558	32	EPSDT - Related	#N/A
45	039	32	EPSDT - Related	#N/A
45	412	32	EPSDT - Related	#N/A
45	550	32	EPSDT - Related	#N/A
45	551	32	EPSDT - Related	#N/A
45	552	32	EPSDT - Related	#N/A
45	553	32	EPSDT - Related	#N/A
45	554	32	EPSDT - Related	#N/A
45	555	32	EPSDT - Related	#N/A
45	556	32	EPSDT - Related	#N/A
45	557	32	EPSDT - Related	#N/A
45	559	32	EPSDT - Related	#N/A
45	560	32	EPSDT - Related	#N/A
45	563	32	EPSDT - Related	#N/A
45	564	32	EPSDT - Related	#N/A
45	565	32	EPSDT - Related	#N/A
45	567	32	EPSDT - Related	#N/A
45	568	32	EPSDT - Related	#N/A
45	569	32	EPSDT - Related	#N/A
45	570	32	EPSDT - Related	#N/A
45	571	32	EPSDT - Related	#N/A

45	573	32	EPSDT - Related	#N/A
45	574	32	EPSDT - Related	#N/A
45	575	32	EPSDT - Related	#N/A
45	576	32	EPSDT - Related	#N/A
45	577	32	EPSDT - Related	#N/A
45	578	32	EPSDT - Related	#N/A
45	579	32	EPSDT - Related	#N/A
45	580	32	EPSDT - Related	#N/A
45	150	32	EPSDT - Related	#N/A
45	999	32	EPSDT - Related	#N/A
11	035	33	Skilled Nursing Home - General	#N/A
82	116	34	Clinical Social Worker	#N/A
82	115	34	Clinical Social Worker	#N/A
82	829	34	Clinical Social Worker	#N/A
85	150	35	Chiropractor	#N/A
85	859	35	Chiropractor	#N/A
86	861	36	Other Lab/X-Ray	#N/A
38	861	36	Other Lab/X-Ray	#N/A
86	251	36	Other Lab/X-Ray	#N/A
86	542	36	Other Lab/X-Ray	#N/A
87	170	37	Physical Therapist	#N/A
87	879	37	Physical Therapist	#N/A
88	171	38	Occupational Therapist	#N/A
88	889	38	Occupational Therapist	#N/A
89	112	39	Psychologist	#N/A
89	899	39	Psychologist	#N/A
90	250	40	Durable Medical Equipment (DME)	#N/A
90	277	40	Durable Medical Equipment (DME)	#N/A
31	080	41	Primary Care (FQHC)	Check for EPSDT Service
31	082	41	Primary Care (FQHC)	Check for EPSDT Service
31	000	41	Primary Care (FQHC)	Check for EPSDT Service
30	111	42	Community Mental Health Centers	#N/A
30	110	42	Community Mental Health Centers	#N/A
30	114	42	Community Mental Health Centers	#N/A
30	118	42	Community Mental Health Centers	#N/A
35	081	43	Rural Health	Check for EPSDT Service
35	000	43	Rural Health	Check for EPSDT Service
72	729	44	Nurse Midwife	#N/A
72	095	44	Nurse Midwife	#N/A
32	083	45	Family Planning - Clinic	#N/A
34	050	46	Home Health	#N/A

34	051	46	Home Health	#N/A
34	210	46	Home Health	#N/A
34	211	46	Home Health	#N/A
37	280	47	Laboratories	#N/A
37	281	47	Laboratories	#N/A
40	183	48	EPSDT - Screens	Check for EPSDT Service
71	000	49	Birthing Centers	#N/A
33	039	50	Supports for Community Living (SCL)(Formerly AIS/MR)	#N/A
42	561	52	Home & Community Based Services	#N/A
43	410	53	Adult Day Care	#N/A
74	094	54	Nurse Anesthetist	#N/A
74	749	54	Nurse Anesthetist	#N/A
44	060	55	Hospice	#N/A
46	080	57	Home Care Waiver	#N/A
46	461	57	Home Care Waiver	#N/A
46	462	57	Home Care Waiver	#N/A
46	463	57	Home Care Waiver	#N/A
46	464	57	Home Care Waiver	#N/A
46	466	57	Home Care Waiver	#N/A
46	465	57	Home Care Waiver	#N/A
47	080	59	Personal Care Waiver	#N/A
47	461	59	Personal Care Waiver	#N/A
47	470	59	Personal Care Waiver	#N/A
47	473	59	Personal Care Waiver	#N/A
47	471	59	Personal Care Waiver	#N/A
47	472	59	Personal Care Waiver	#N/A
17	179	60	Brain Injury	#N/A
55	261	62	Ambulance	#N/A
55	260	62	Ambulance	#N/A
57	671	63	Non-Emergency Transportation	#N/A
56	261	63	Non-Emergency Transportation	#N/A
56	262	63	Non-Emergency Transportation	#N/A
56	263	63	Non-Emergency Transportation	#N/A
56	264	63	Non-Emergency Transportation	#N/A
56	265	63	Non-Emergency Transportation	#N/A
56	266	63	Non-Emergency Transportation	#N/A
56	267	63	Non-Emergency Transportation	#N/A
56	661	63	Non-Emergency Transportation	#N/A
54	240	64	Pharmacy	#N/A
54	000	64	Pharmacy	#N/A
14	000	65	MFP Transition	#N/A

17	000	66	MFP Post-Transition	#N/A
33	000	66	MFP Post-Transition	#N/A
41	000	66	MFP Post-Transition	#N/A
42	000	66	MFP Post-Transition	#N/A
43	000	66	MFP Post-Transition	#N/A
52	000	67	Optometry	#N/A
77	000	67	Optometry	#N/A
52	180	67	Optometry	#N/A
52	190	67	Optometry	#N/A
52	528	67	Optometry	#N/A
77	180	67	Optometry	#N/A
77	779	67	Optometry	#N/A
60	271	72	Dental	#N/A
60	272	72	Dental	#N/A
60	273	72	Dental	#N/A
60	274	72	Dental	#N/A
60	277	72	Dental	#N/A
61	271	72	Dental	#N/A
61	272	72	Dental	#N/A
61	273	72	Dental	#N/A
61	274	72	Dental	#N/A
61	277	72	Dental	#N/A
61	610	72	Dental	#N/A
60	270	72	Dental	#N/A
60	275	72	Dental	#N/A
60	276	72	Dental	#N/A
61	270	72	Dental	#N/A
61	275	72	Dental	#N/A
61	276	72	Dental	#N/A
65	313	74	Physicians	Check for EPSDT Service
65	315	74	Physicians	Check for EPSDT Service
65	316	74	Physicians	Check for EPSDT Service
65	317	74	Physicians	Check for EPSDT Service
65	319	74	Physicians	Check for EPSDT Service
65	320	74	Physicians	Check for EPSDT Service
65	323	74	Physicians	Check for EPSDT Service
65	327	74	Physicians	Check for EPSDT Service
65	334	74	Physicians	Check for EPSDT Service
65	335	74	Physicians	Check for EPSDT Service
65	338	74	Physicians	Check for EPSDT Service
65	340	74	Physicians	Check for EPSDT Service

65	344	74	Physicians	Check for EPSDT Service
65	346	74	Physicians	Check for EPSDT Service
65	347	74	Physicians	Check for EPSDT Service
65	348	74	Physicians	Check for EPSDT Service
64	112	74	Physicians	Check for EPSDT Service
64	272	74	Physicians	Check for EPSDT Service
64	310	74	Physicians	Check for EPSDT Service
64	311	74	Physicians	Check for EPSDT Service
64	312	74	Physicians	Check for EPSDT Service
64	314	74	Physicians	Check for EPSDT Service
64	318	74	Physicians	Check for EPSDT Service
64	321	74	Physicians	Check for EPSDT Service
64	322	74	Physicians	Check for EPSDT Service
64	324	74	Physicians	Check for EPSDT Service
64	325	74	Physicians	Check for EPSDT Service
64	326	74	Physicians	Check for EPSDT Service
64	327	74	Physicians	Check for EPSDT Service
64	328	74	Physicians	Check for EPSDT Service
64	330	74	Physicians	Check for EPSDT Service
64	331	74	Physicians	Check for EPSDT Service
64	332	74	Physicians	Check for EPSDT Service
64	333	74	Physicians	Check for EPSDT Service
64	336	74	Physicians	Check for EPSDT Service
64	337	74	Physicians	Check for EPSDT Service
64	338	74	Physicians	Check for EPSDT Service
64	339	74	Physicians	Check for EPSDT Service
64	341	74	Physicians	Check for EPSDT Service
64	342	74	Physicians	Check for EPSDT Service
64	343	74	Physicians	Check for EPSDT Service
64	345	74	Physicians	Check for EPSDT Service
65	272	74	Physicians	Check for EPSDT Service
65	293	74	Physicians	Check for EPSDT Service
65	310	74	Physicians	Check for EPSDT Service
65	311	74	Physicians	Check for EPSDT Service
65	312	74	Physicians	Check for EPSDT Service
65	314	74	Physicians	Check for EPSDT Service
65	318	74	Physicians	Check for EPSDT Service
65	321	74	Physicians	Check for EPSDT Service
65	322	74	Physicians	Check for EPSDT Service
65	324	74	Physicians	Check for EPSDT Service
65	325	74	Physicians	Check for EPSDT Service

65	326	74	Physicians	Check for EPSDT Service
65	328	74	Physicians	Check for EPSDT Service
65	330	74	Physicians	Check for EPSDT Service
65	331	74	Physicians	Check for EPSDT Service
65	332	74	Physicians	Check for EPSDT Service
65	333	74	Physicians	Check for EPSDT Service
65	336	74	Physicians	Check for EPSDT Service
65	337	74	Physicians	Check for EPSDT Service
65	339	74	Physicians	Check for EPSDT Service
65	341	74	Physicians	Check for EPSDT Service
65	342	74	Physicians	Check for EPSDT Service
65	343	74	Physicians	Check for EPSDT Service
65	345	74	Physicians	Check for EPSDT Service
65	650	74	Physicians	Check for EPSDT Service
64	000	74	Physicians	Check for EPSDT Service
65	000	74	Physicians	Check for EPSDT Service
64	313	74	Physicians	Check for EPSDT Service
64	315	74	Physicians	Check for EPSDT Service
64	316	74	Physicians	Check for EPSDT Service
64	317	74	Physicians	Check for EPSDT Service
64	319	74	Physicians	Check for EPSDT Service
64	320	74	Physicians	Check for EPSDT Service
64	323	74	Physicians	Check for EPSDT Service
64	334	74	Physicians	Check for EPSDT Service
64	335	74	Physicians	Check for EPSDT Service
64	340	74	Physicians	Check for EPSDT Service
64	344	74	Physicians	Check for EPSDT Service
64	346	74	Physicians	Check for EPSDT Service
64	347	74	Physicians	Check for EPSDT Service
64	348	74	Physicians	Check for EPSDT Service
64	329	74	Physicians	Check for EPSDT Service
65	329	74	Physicians	Check for EPSDT Service
64	543	74	Physicians	Check for EPSDT Service
78	090	75	Nurse Practitioner/Midwife	Check for EPSDT Service
78	091	75	Nurse Practitioner/Midwife	Check for EPSDT Service
78	092	75	Nurse Practitioner/Midwife	Check for EPSDT Service
78	093	75	Nurse Practitioner/Midwife	Check for EPSDT Service
78	095	75	Nurse Practitioner/Midwife	Check for EPSDT Service
78	789	75	Nurse Practitioner/Midwife	Check for EPSDT Service
78	000	75	Nurse Practitioner/Midwife	Check for EPSDT Service
50	220	81	Hearing	#N/A

70	200	81	Hearing	#N/A
50	509	81	Hearing	#N/A
70	709	81	Hearing	#N/A
80	140	88	Podiatry	#N/A
80	809	88	Podiatry	#N/A
91	911	90	Comp. Outpatient Rehab. Facility	#N/A
91	912	90	Comp. Outpatient Rehab. Facility	#N/A
92	011	92	Psych Distinct Part Unit	#N/A
93	040	93	Rehab Distinct Part Unit	#N/A
93	012	93	Rehab Distinct Part Unit	#N/A
95	100	94	Physician Assistant	#N/A
95	959	94	Physician Assistant	#N/A
95	101	94	Physician Assistant	#N/A
96	071	96	Managed Care - Physical Health	#N/A
96	072	96	Managed Care - Physical Health	#N/A
97	000	97	Managed Care - Behavioral Health	#N/A

Exhibit:	E	Created:	09/07/2011
Name:	EPSDT Category of Service Crosswalk	Last Revised:	09/07/2011
Reports:	78		

EPSDT Services may be provided by the following Provider Types.

Billing Provider Type	Billing Provider Type Description	Note
20	Preventive & Remedial Public Health	Check for EPSDT Service
31	Primary Care	Check for EPSDT Service
35	Rural Health Clinic	Check for EPSDT Service
40	EPSDT Preventive Services	Check for EPSDT Service
64	Physician Individual	Check for EPSDT Service
65	Physician - Group	Check for EPSDT Service
78	Certified Nurse practitioner	Check for EPSDT Service

The following procedures outline how EPSDT Services are to be allocated to Category of Service:

1. Verify Member Age <= 20
2. Claims submitted by one of the billing provider types, with a procedure code in HCPC procedure code group 1124 will be flagged as having EPSDT services, and the category of service set to 48 – EPSDT

HCPC procedure code group 1124

99381	99385	99394	WP101	WP113
99382	99391	99395	WP102	WP114

99383	99392	99431	WP111	WP115
99384	99393	99432	WP112	

3. Claims submitted by one of the billing provider types, with a procedure code in HCPC procedure code group 44, also require a well-child diagnosis code. These codes are in, diagnosis code group 20. Claims with a procedure code in group 44 and a diagnosis code in group 20 will be flagged as having EPSDT services, and the category of service set to 48 – EPSDT

Diagnosis code group 20

V20	V202	V704	V707
V200	V700	V705	V708
V201	V703	V706	V709

HCPC procedure code group 44

99201	99202	99203	99204	99205
99211	99212	99213	99214	99215

Exhibit:	F	Created:	09/07/2011
Name:	Medicaid Eligibility Group Crosswalk	Last Revised:	09/07/2011
Reports:	78		

Medicaid Eligibility Groups (MEGs) are defined below. The order of priority provided below must be followed when MCO Enrollees are classified in a MEG.

1. MEG 1: Dual Medicare and Medicaid:
   Rate Cell definitions identify the Members to be grouped into this MEG.
2. MEG 2: SSI Adults, SSI Children and Foster Care:
   Rate Cell definitions identify the Members to be grouped into this MEG.
3. MEG 3: MCHIP:
   MCHIP is a Medicaid expansion population defined as Program Code = I and Status Code = P5 or P6
4. MEG 4: SCHIP:
   SCHIP is a standalone population defined as Program Code = I and Status Code = P7.
5. MEG 5: Children 18 and Under.
   MCO enrollee where age is determined based on the Enrollee's age on last day of the month.
6. MEG 6: Adults over 18
   MCO Enrollees where age is determined based on the Enrollee's age on last day of the month.

Exhibit:	G	Created:	10/19/2011
Name:	BHDID General Population Definitions	Last Revised:	10/25/2011
Reports:	97, 98, 99, 100, 101		

Adults with Mental Illness (General Adult MH Population)

- adults (age 18 and over) (age calculated by service date), **and**

- who are receiving behavioral health (mental health or substance abuse) Medicaid billable or non-Medicaid billable services (on the procedure code listing provided), **and**
- have a MH Diagnosis at any time during the reporting year (during initial year – through the time of the MCO experience – *applies to all population counts*).

Adults with Mental Illness (SMI Population)

1. if CMHC provider, have an SMI marker = yes (MCOs can receive the marker from the CMHCs) at any time during the reporting year.)

or

2. All four (4) criteria below are met (age, diagnosis, disability, and duration).

- Age: adults (age 18 and over) (age calculated by service date) who are receiving behavioral health (mental health or substance abuse) Medicaid billable or non-Medicaid billable services (on the procedure code listing provided), **and**
- Diagnosis: has one or more of the specific MH DSM Diagnoses listed below.

PSYCHOTIC DISORDERS	
Schizophrenia	295.xx (.30, .10, .20, .90, .60)
Schizophreniform Disorder	295.40
Schizoaffective Disorder	295.70
Delusional Disorder	297.1
Psychotic Disorder (NOS)	298.9
MOOD DISORDERS	
Major Depressive Disorder	296.2x (single episode) 296.3x (recurrent)
Dysthymic Disorder	300.4
Depressive Disorder NOS	311
Bipoloar I Disorder	296.0x, 296.40, 296.4x, 296, 296.5x, 296. 6x, 296.7
Bipoloar II Disorder	296.89
Bipoloar Disorder NOS	296.80
Cyclothymic Disorder	301.13

, **and**

- Disability: Clear evidence of functional impairment in two or more of the following domains:
  - Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores.
  - Interpersonal Functioning: How well the person establishes and maintains personal relationship. Relationships included those made at work and in the family settings as well as those that exist in other settings.
  - Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, gender and culture.
  - Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries.
  1. Cognitive/Intellectual Functioning: Person's overall thought processes, capacity, style and memory in relation to what is common for the person's age, gender, and culture. Person's response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating.

, **and**

- Duration: One or more of these conditions of duration:
  1. Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two (2) years.

2. The individual has been hospitalized for mental illness more than once in the last two (2) years.
3. There is a history of one or more episodes with marked disability and the illness is expected to continue for a two-year period of time.

Children/Youth with Mental Illness (General Child/Youth MH Population)

- child/youth (age <18) (age calculated by service date), **and**
- who are receiving behavioral health (mental health or substance abuse) Medicaid billable or non-Medicaid billable services (on the procedure code listing provided), **and**
- have a MH Diagnosis at any time during the reporting year.

Children/Youth with Mental Illness (SED Population)

1. if CMHC provider, have an SED marker = yes (MCOs can receive the marker from the CMHCs) at any time during the reporting year.)

or

2. All four (4) criteria below are met as established by KRS 200.503 (age, diagnosis, disability, and duration).

- Age: is under age 18, or under age 21 and was receiving mental health services prior to age 18, and for who the services must be continued for therapeutic benefit, **and**
- Diagnosis: has a clinically significant disorder of thought, mood, perception, orientation, memory, and or behavior that is listed in the current addition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. The following table specifies Kentucky's disorders most frequently associated with SED.

PSYCHOTIC DISORDERS	
Schizophrenia	295.xx (.30, .10, .20, .90, .60)
Schizophreniform Disorder	295.40
Schizoaffective Disorder	295.70
Delusional Disorder	297.1
Psychotic Disorder (NOS)	298.9
ANXIETY DISORDERS	
Anxiety Disorders	300.00, 300.2x (.21, .22, .23, .29)
Obsessive-Compulsive Disorder	300.3
Acute Stress Disorder	308.3
Posttraumatic Stress Disorder	309.81
DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE	
Oppositional Defiant Disorder	313.81
Disruptive Behavior Disorder NOS	312.9
Reactive Attachment Disorder	313.89
Conduct Disorder	312.8x (.81, .82, .89)
Attention-Deficit/Hyperactivity Disorder	314.xx (.01, .00, .9)
PERVASIVE DEVELOPMENTAL DISORDERS	
Autistic Disorder	299.00
Asperger's Disorder	299.80

MOOD DISORDERS	
Major Depressive Disorder	296.3x (recurrent)
Dysthymic Disorder	300.4
Depressive Disorder NOS	311
Bipoloar I Disorder	296.0x, 296.40, 296.4x, 296, 296.5x, 296. 6x, 296.7
Bipoloar II Disorder	296.89
Bipoloar Disorder NOS	296.80
Cyclothymic Disorder	301.13

Or (Adjustment Disorders 309.xx (.0, .24, .28, .3,..4, .9) and age <8 years)

, **and**

- Disability & Duration:
  1. presents substantial limitations which have persisted for at least one year, or are judged by a mental health professional to be at high risk of continuing for one year without professional intervention in at least two of these five areas:
     1. Self Care
     2. Interpersonal relationships
     3. Family Life
     4. Self-Direction
     5. Education

or

2. is a Kentucky resident and is receiving residential treatment for an emotional disability through the interstate compact;

or

3. has been removed from the home by the Department for Community Based Services (Kentucky's child welfare agency) and has been unable to be maintained in a stable setting due to a behavioral emotional disability.

Exhibit:	H	Created:	10/15/2011
Name:	MH/SA Procedures Codes	Last Revised:	
Reports:	97, 98, 99, 110		

A listing of MH/SA Procedure Codes is provided below. The MH/SA procedure code list is provided as a guide and may change based on industry practices. Note: Not all Procedure Codes will be applicable to the MCO covered population and MCO covered services.

Good and Modern Benefits: Procedure Codes and Titles Sorted by Good and Modern Category and Subcategory

Good and Modern Category		Procedure Code	Procedure Title
Category	**Subcategory**		
HEALTHCARE HOMES/PHYSICAL HEALTH			
Healthcare Home/Physical Health	General and specialized outpatient services	N/A	
Healthcare Home/Physical Health	Acute pimary care	N/A	

Healthcare Homes/Physical Health	General health screens, tests and immunizations	N/A	
Healthcare Homes/Physical Health	General and specialized outpatient services	N/A	
Healthcare Homes/Physical Health	Acute pimary care	N/A	
Healthcare Homes/Physical Health	General health screens, tests and immunizations	N/A	
Healthcare Home/Physical Health	Comprehensive Care management	S0280	Medical home program, comprehensive care coordination and planning, initial plan
Healthcare Home/Physical Health	Comprehensive Care management	S0281	Medical home program, comprehensive care coordination and planning, maintenance of plan
Healthcare Homes/Physical Health	Comprehensive Care Management	90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
Healthcare Homes/Physical Health	Care coordination and health promotion	N/A	
Healthcare Homes/Physical Health	Comprehensive Transitional Care	N/A	
Healthcare Homes/Physical Health	Individual and Family Support	N/A	
Healthcare Homes/Physical Health	Referral to Communtiy Services	N/A	
PREVENTION			
Prevention	Facilitated Referrals	H0022	Alcohol and/or drug intervention service (planned facilitation)
Prevention	Facilitated Referrals	H0026	Alcohol and/or drug intervention service (planned facilitation)
Prevention	Facilitated Referrals	H0028	Alcohol and/or drug prevention problem identification and referral service

Prevention	Screening and Brief Intervention for Tobacco Cessation	99406	Smoking and tobacco cessation counseling visit, intermediate, greater than 3 minutes up to 10 minutes
Prevention	Screening and Brief Intervention for Tobacco Cessation	99407	Smoking and tobacco cessation counseling visit, greater than 10 minutes
Prevention	Screening and Brief Intervention for Tobacco Cessation	G0436	Tobacco-use counsel 3-10 min
Prevention	Screening and Brief Intervention for Tobacco Cessation	G0437	Tobacco-use counsel>10min
Prevention	Screening and Brief Intervention for Tobacco Cessation	G8402	Tobacco (smoke) use cessation intervention, counseling
Prevention	Screening, Brief intervention and Referral to Treatment	H0049	Alcohol and/or drug Screening
Prevention	Screening, Brief Intervention, and Referral to Treatment	99408	Alcohol and substance (other than tobacco) abuse structure screening (e.g., AUDIT, DAST) and brief intervention (SBI) services; 15-30 minutes
Prevention	Screening, Brief Intervention, and Referral to Treatment	G0396	Alcohol/subs interv 15-30mn
Prevention	Screening, Brief Intervention, and Referral to Treatment	G0397	Alcohol/subs interv >30 min
Prevention	Screening, Brief Intervention, and Referral to Treatment	H0050	Alcohol and/or Drug Service, Brief Intervention; per 15 minutes
Prevention	Wellness Recovery Support	H0029	Alcohol and/or drug prevention alternatives service (services for populations that exclude alcohol and other drug use e.g. alcohol free social events)
Prevention	Parent Training	N/A	
Prevention	Brief Motivational Interviews	N/A	
Prevention	Warm Line	N//A	
ENGAGEMENT SERVICES			

Engagement Services	Assessment	H0001	Alcohol and/or drug assessment
Engagement Services	Assessment	96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and
Engagement Services	Assessment	H0002	Behavioral Health Screen to determine eligibility for admission to treatment program
Engagement Services	Assessment	96111	Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report
Engagement Services	Assessment	96110	Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report
Engagement Services	Assessment	H1011	Family assessment by licensed behavioral health professional for state defined purposes
Engagement Services	Assessment	96150	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psycho physiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment
Engagement Services	Assessment	96151	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psycho physiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment

Engagement Services	Assessment	90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication
Engagement Services	Assessment	H0031	Mental health assessment, by non-physician
Engagement Services	Assessment	T1001	Nursing Assessment/ Evaluation
Engagement Services	Assessment	H1000	Prenatal care, at-risk assessment
Engagement Services	Assessment	90889	Preparation of report of patients psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers
Engagement Services	Assessment	90801	Psychiatric diagnostic interview examination
Engagement Services	Assessment	90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes
Engagement Services	Assessment	96101	Psychological Testing – Psycho diagnostic assessment of emotionality, intellectual abilities; personality and psychopathology e.g. MMP, Rorschach, WAIS (per hour of psychologist's or physician's time, both face-to-face with the patient and time inte
Engagement Services	Assessment	96102	Psychological Testing – Psycho diagnostic assessment of emotionality, intellectual abilities; personality and psychopathology e.g. MMP, Rorschach, WAIS) with qualified healthcare professional interpretation and report, administered by technician, pe

Engagement Services	Assessment	96103	Psychological testing (includes psycho diagnostic assessment of emotionality, intellectual abilities; personality and psychopathology, e.g.. MMPI, Rorschach, WAIS) administered by a computer, with qualified health care professional interpretation and r
Engagement Services	Assessment	96100	Psychological testing (includes psycho diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI) with interpretation and report; per hour
Engagement Services	Assessment	96125	Standardized cognitive performance testing (e.g.. Ross Information Processing Assessment) per hour of a qualified health care professionals time, both face-to-face time administering tests to the patient and time interpreting these test results and p
Engagement Services	Assessment	99456	Work related or medical disability examination by other than the treating physician
Engagement Services	Consumer/Family Education	H1010	Non-medical family planning education; per session
Engagement Services	Consumer/Family Education	S9446	Patient education, not otherwise classified, non-physician provider, group; per session
Engagement Services	Consumer/Family Education	H1003	Prenatal care, at-risk enhanced service; education
Engagement Services	Outreach	H0023	Behavioral health outreach service (planned approach to reach a targeted population)
Engagement Services	Service Planning (including crisis planning)	H0032	Mental health service plan development by non-physician
Engagement Services	Service Planning (including crisis planning)	T1007	Alcohol and/or substance abuse services, treatment plan development and/or modification
Engagement Services	Service Planning (including crisis planning)	00100	Early intervention/individualized family service plan (IFSP)

Engagement Services	Specialized evaluations (psychological, neurological)	G8405	lower extremity neurological exam not performed
Engagement Services	Specialized evaluations (psychological, neurological)	G8404	lower extremity neurological exam performed and documented
Engagement Services	Specialized evaluations (psychological, neurological)	96115	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report; per hour
Engagement Services	Specialized evaluations (psychological, neurological)	96116	Neurobehavioral status exam (clinical) assessment of thinking, reasoning and judgment, e.g., acquired knowledge attention, language, memory, planning and problem solving, and problem solving, and visual spatial abilities); per hour of the psychologist
Engagement Services	Specialized evaluations (psychological, neurological)	96117	Neuropsychological testing battery (e.g., Halstead-Reitan, Luria, WAIS-R) with interpretation and report; per hour
Engagement Services	Specialized evaluations (psychological, neurological)	T2010	Preadmission screening and resident review (pasrr) level i identification screening; per screen
Engagement Services	Specialized evaluations (psychological, neurological)	T2011	Preadmission screening and resident review level ii evaluation; per evaluation
Engagement Services	Specialized evaluations (psychological, neurological)	T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol; per encounter
OUTPATIENT SERVICES			
Outpatient Services	Family Therapy	90846	Family psychotherapy (without the patient present)
Outpatient Services	Family Therapy	90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
Outpatient Services	Family Therapy	96154	Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)

Outpatient Services	Family Therapy	96155	Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)
Outpatient Services	Family Therapy	99510	Home visit for individual, family, or marriage counseling
Outpatient Services	Family Therapy	T1006	Alcohol and/or substance abuse services, family/couple counseling
Outpatient Services	Group Therapy	90853	Group psychotherapy (other than of a multiple-family group)(NC)
Outpatient Services	Group Therapy	90857	Interactive group psychotherapy
Outpatient Services	Group Therapy	96153	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)
Outpatient Services	Group Therapy	H0005	Alcohol and/or drug services; group counseling by a clinician
Outpatient Services	Individual Evidenced-Based Therapies	90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
Outpatient Services	Individual Evidenced-Based Therapies	90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
Outpatient Services	Individual Evidenced-Based Therapies	90806	Practitioner Level 1, In-Clinic face-to-face with patient with medical evaluation and management services
Outpatient Services	Individual Evidenced-Based Therapies	90807	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
Outpatient Services	Individual Evidenced-Based Therapies	90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient

Outpatient Services	Individual Evidenced-Based Therapies	90809	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
Outpatient Services	Individual Evidenced-Based Therapies	90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
Outpatient Services	Individual Evidenced-Based Therapies	90811	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
Outpatient Services	Individual Evidenced-Based Therapies	90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
Outpatient Services	Individual Evidenced-Based Therapies	90813	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
Outpatient Services	Individual Evidenced-Based Therapies	90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient

Outpatient Services	Individual Evidenced-Based Therapies	90815	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;
Outpatient Services	Individual Evidenced-Based Therapies	90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 45 to 50 minutes face-to-face with the patient
Outpatient Services	Individual Evidenced-Based Therapies	90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 75 to 80 minutes face-to-face with the patient
Outpatient Services	Individual Evidenced-Based Therapies	90822	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
Outpatient Services	Individual Evidenced-Based Therapies	90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital or residential care setting, approximately 20 to 30 minutes face-to-face

Outpatient Services	Individual Evidenced-Based Therapies	90824	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face
Outpatient Services	Individual Evidenced-Based Therapies	90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital or residential care setting, approximately 45 to 50 minutes face-to-face
Outpatient Services	Individual Evidenced-Based Therapies	90827	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face
Outpatient Services	Individual Evidenced-Based Therapies	90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital or residential care setting, approximately 75 to 80 minutes face-to-face
Outpatient Services	Individual Evidenced-Based Therapies	90829	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face
Outpatient Services	Individual Evidenced-Based Therapies	90845	Psychoanalysis

Outpatient Services	Individual Evidenced-Based Therapies	90870	Electroconvulsive therapy (includes necessary monitoring); single seizure
Outpatient Services	Individual Evidenced-Based Therapies	90871	Electroconvulsive therapy (includes necessary monitoring); multiple seizures; per day
Outpatient Services	Individual Evidenced-Based Therapies	90875	Individual psycho physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes
Outpatient Services	Individual Evidenced-Based Therapies	90876	Individual psycho physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes
Outpatient Services	Individual Evidenced-Based Therapies	90880	Hypnotherapy
Outpatient Services	Individual Evidenced-Based Therapies	96152	Health and behavior intervention, each 15 minutes, face-to-face; individual
Outpatient Services	Individual Evidenced-Based Therapies	99510	Home visit for individual, family, or marriage counseling
Outpatient Services	Individual Evidenced-Based Therapies	H0004	behavioral health counseling and therapy; per 15 minutes
Outpatient Services	Individual Evidenced-Based Therapies	H2012	Behavioral health day treatment; per hour
Outpatient Services	Individual Evidenced-Based Therapies	H2032	Activity Therapy
Outpatient Services	Individual Evidenced-Based Therapies	H2035	Alcohol and/or drug treatment program; per hour
Outpatient Services	Multi-Family Counseling	90849	Multiple-family group psychotherapy (with patient present)
Outpatient Services	Consultation to Caregivers	N/A	
MEDICATION SERVICES			
Medication Services	Laboratory Services	H0003	Alcohol and/or drug screening; laboratory analysis of specimens for presence of alcohol or drugs

Medication Services	Laboratory Services	H0048	Alcohol and/or other drug testing: collection and handling only, specimens other than blood
Medication Services	Medication Management	H0034	Medication training and support; per 15 minutes
Medication Services	Medication Management	H2010	Comprehensive medication services; per 15 minutes
Medication Services	Medication Management	90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
Medication Services	Pharmacotherapy (including Medication Assisted Tx)	H0033	Oral medication administration, direct observation
Medication Services	Pharmacotherapy (including Medication Assisted Tx)	T1502	Administration of Oral, Intra-muscular, and/or Subcutaneous Medication by Health Care Agency/Professional; per visit
Medication Services	Pharmacotherapy (including Medication Assisted Tx)	H0020	Alcohol and/or drug services; methadone administration and/or service (provisions of the drug by a licensed program)
Medication Services	Pharmacotherapy (including Medication Assisted Tx)	M0064	Brief Office Visit for the Sole Purpose of Monitoring or Changing Drug Prescriptions Used in the Treatment of Mental Psychoneurotic and Personality Disorders
Medication Services	Pharmacotherapy (including Medication Assisted Tx)	J0592	Injection, buprenorphine hydrochloride, 0.1 mg
Medication Services	Pharmacotherapy (including Medication Assisted Tx)	J1230	Injection, methadone hcl, up to 10 mg
Medication Services	Pharmacotherapy (including Medication Assisted Tx)	J2315	Injection, naltrexone, depot form, 1 mg
Medication Services	Pharmacotherapy (including Medication Assisted Tx)	S0109	Methadone, oral, 5mg
Medication Services	Pharmacotherapy (including Medication Assisted Tx)	J8499	Prescription drug, oral, non chemotherapeutic, NOS

COMMUNITY SUPPORT			
Community Support (Rehabilitative)	Case Management	H0006	Alcohol and/or drug services; case management
Community Support (Rehabilitative)	Case Management	T1016	Case management, each 15 minutes
Community Support (Rehabilitative)	Case Management	T1017	Targeted case management, each 15 minutes
Community Support (Rehabilitative)	Comprehensive community support services	H0037	Community psychiatric supportive treatment program; per diem
Community Support (Rehabilitative)	Comprehensive community support services	H2015	Comprehensive community support services; per 15 minutes
Community Support (Rehabilitative)	Comprehensive community support services	H2016	Comprehensive community support services; per diem
Community Support (Rehabilitative)	Comprehensive community support services	H2021	Community-based wrap-around services; per 15 Modified
Community Support (Rehabilitative)	Parent/caregiver support; skill building	G0177	Training and educational services related to the care and treatment of patients disabling mental health problems per session (45 minutes or more)
Community Support (Rehabilitative)	Parent/Caregiver Support Services	S5110	Home care training, family; per 15 minutes
Community Support (Rehabilitative)	Parent/Caregiver Support Services	S5111	Home care training, family; per session
Community Support (Rehabilitative)	Parent/Caregiver Support Services	T1027	Family training & counseling
Community Support (Rehabilitative)	Permanent Supportive Housing	H0043	Supported housing; per diem
Community Support (Rehabilitative)	Permanent Supportive Housing	H0044	Supported housing; per month
Community Support (Rehabilitative)	Recovery Housing	H2034	Alcohol and/or drug abuse halfway house services; per diem
Community Support (Rehabilitative)	Skill Building (Social, Daily Living, Cognitive)	H2014	Skills training and development; per 15 minutes
Community Support (Rehabilitative)	Skill Building (Social, Daily Living, Cognitive)	H2017	Psychosocial rehabilitation services; per 15 minutes
Community Support (Rehabilitative)	Skill Building (Social, Daily Living, Cognitive)	H2018	Psychosocial rehabilitation services; per diem

Community Support (Rehabilitative)	Skill Building (Social, Daily Living, Cognitive)	H2027	Psycho educational service; per 15 minutes
Community Support (Rehabilitative)	Skill building; Behavioral management	H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude, and/or behavior)
Community Support (Rehabilitative)	Skills Building (social, daily living, cognitive)	T1012	Alcohol and/or substance abuse services, skills development
Community Support (Rehabilitative)	Supported Employment	H2023	Supported employment; per 15 minutes
Community Support (Rehabilitative)	Supported Employment	H2024	Supported employment; per diem
Community Support (Rehabilitative)	Supported Employment	H2025	Ongoing support to maintain employment; per 15 minutes
Community Support (Rehabilitative)	Supported Employment	H2026	Ongoing support to maintain employment; per diem
Community Support (Rehabilitative)	Behavioral Management	H2019	Therapeutic behavioral services; per 15 minutes
Community Support (Rehabilitative)	Behavioral Management	H2020	Therapeutic behavioral services; per diem
Community Support (Rehabilitative)	Therapeutic Mentoring	N/A	
Community Support (Rehabilitative)	Traditional Healing Services	N/A	
OTHER SUPPORTS			
Other Supports (Habilitative)	Homemaker	S5130	Homemaker service, nos; per 15 minutes
Other Supports (Habilitative)	Homemaker	S5131	Homemaker service, nos; per diem
Other Supports (Habilitative)	Personal Care	S5125	Attendant care services; per 15 minutes
Other Supports (Habilitative)	Personal Care	T1019	Personal care services; per 15 minutes
Other Supports (Habilitative)	Personal Care	T1020	Personal care services; per diem
Other Supports (Habilitative)	Recreation Services	G0176	Recreation, related to the care and treatment of patients disabling mental health problems; per session (45 minutes or more)
Other Supports (Habilitative)	Respite	H0045	Respite care services, not in the home; per diem

Other Supports (Habilitative)	Respite	S5150	Unskilled respite care, not hospice; per 15 minutes
Other Supports (Habilitative)	Respite	S5151	Unskilled respite care, not hospice; per diem
Other Supports (Habilitative)	Respite	S9125	Respite care, in the home; per diem
Other Supports (Habilitative)	Respite	T1005	Respite care services, up to 15 minutes
Other Supports (Habilitative)	Trained Behavioral Health Interpreters	T1013	Sign language or oral interpretive services; per 15 minutes
Other Supports (Habilitative)	Transportation	A0080	Non-emergency transportation; per mile-vehicle provided by volunteer (individual or organization), with no vested interest
Other Supports (Habilitative)	Transportation	A0090	Non-emergency transportation; per mile-vehicle provided by individual (family member, self, neighbor) with vested interest
Other Supports (Habilitative)	Transportation	A0110	Non-emergency transportation an bus, intra or inter state carrier
Other Supports (Habilitative)	Transportation	A0120	Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems
Other Supports (Habilitative)	Transportation	A0130	Non-emergency transportation: wheel-chair van
Other Supports (Habilitative)	Transportation	A0140	Non-emergency transportation and air travel (private or commercial) intra- or inter-state
Other Supports (Habilitative)	Transportation	A0160	Non-emergency transportation: per mile-Case worker or social worker
Other Supports (Habilitative)	Transportation	A0170	Transportation ancillary: parking fees, tolls, other
Other Supports (Habilitative)	Transportation	S0215	Non-emergency transportation; mileage; per mile;
Other Supports (Habilitative)	Transportation	T2001	Non emergency transportation; patient attendant/escort
Other Supports (Habilitative)	Transportation	T2002	Non-emergency transportation; per diem
Other Supports (Habilitative)	Transportation	T2003	Non-emergency transportation; encounter/trip
Other Supports (Habilitative)	Transportation	T2004	Non-emergency transport; commercial carrier, multi-pass

Other Supports (Habilitative)	Transportation	T2005	Non-emergency transportation; stretch van
Other Supports (Habilitative)	Transportation	T2039	Vehicle modifications, waiver; per service (NC- Vehicle Adaptations)
Other Supports (Habilitative)	Assisted Living	N/A	
Other Supports (Habilitative)	Supported Education	N/A	
Other Supports (Habilitative)	Interactive Communication Devices	N/A	
INTENSIVE SUPPORT SERVICES			
Intensive Support Services	Intensive home-based treatment	90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 45 to 50 minutes face-to-face with the patient
Intensive Support Services	Intensive home-based treatment	90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital or residential care setting, approximately 20 to 30 minutes face-to-face
Intensive Support Services	Intensive home-based treatment	90827	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face
Intensive Support Services	Assertive Community Treatment	H0039	Assertive Community Treatment
Intensive Support Services	Assertive Community Treatment	H0040	Assertive Community Treatment; per diem
Intensive Support services	Intensive case management	T1024	Team evaluation & management
Intensive Support services	Intensive home based treatment	H1004	Prenatal care, at-risk enhanced service; follow-up home visit

Intensive Support Services	Intensive home-based treatment	H0036	Intensive Family Intervention
Intensive Support Services	Intensive home-based treatment	H2022	Community-based wrap-around services; per diem (intensive in-home services)
Intensive Support Services	Intensive home-based treatment	S9482	Family stabilization services; per 15 minutes
Intensive Support Services	Multi-systemic Therapy	H2033	Multi-systemic Therapy for Juveniles; per 15 minutes
Intensive Support Services	Partial hospitalization	90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 20 to 30 minutes face-to-face with the patient (one unit maximum per session)
Intensive Support Services	Partial hospitalization	90817	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
Intensive Support Services	Partial Hospitalization	90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 45 to 50 minutes face-to-face with the patient
Intensive Support Services	Partial hospitalization	90819	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services

Intensive Support Services	Partial hospitalization	90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 75 to 80 minutes face-to-face with the patient
Intensive Support Services	Partial hospitalization	90822	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
Intensive Support Services	Partial hospitalization	90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital or residential care setting, approximately 20 to 30 minutes face-to-face
Intensive Support Services	Partial hospitalization	90824	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face
Intensive Support Services	Partial hospitalization	90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital or residential care setting, approximately 45 to 50 minutes face-to-face

Intensive Support Services	Partial hospitalization	90827	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face
Intensive Support Services	Partial hospitalization	90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital or residential care setting, approximately 75 to 80 minutes face-to-face
Intensive Support Services	Partial Hospitalization	G0410	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
Intensive Support Services	Partial Hospitalization	G0411	Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes
Intensive Support Services	Partial hospitalization	H0014	Alcohol and/or drug services; ambulatory detoxification
Intensive Support Services	Partial Hospitalization	H0035	Mental health partial hospitalization, treatment, less than 24 hours
Intensive Support Services	Partial Hospitalization	S0201	Alcohol and/or drug treatment program; per hour
Intensive Support Services	Partial Hospitalization	S9480	Intensive outpatient psychiatric services; per diem
Intensive Support Services	SA Ambulatory Detox	H0008	Alcohol and/or drug services; sub acute detoxification (outpatient)
Intensive support services	SA Ambulatory Detox	H0014	Alcohol and/or drug services; ambulatory detoxification
Intensive Support Services	SA Ambulatory Detox	H0016	Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)
Intensive support services	SA Ambulatory Detox	S9475	Ambulatory setting substance abuse treatment or detoxification services; per diem

Intensive Support Services	Substance Abuse Intensive outpatient	H0015	Alcohol and/or drug services; intensive outpatient treatment (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan) including assessment, counseling, crisis intervention, and activity therapies or education
Intensive Support Services	Substance Abuse Intensive Outpatient Services	T2025	Waiver Services; not otherwise specified (NOS)
Intensive Support Services	Intensive case management		Use case management codes as applicable
OUT-OF-HOME RESIDENTIAL			
Out-of-Home Residential	Clinically Managed 24-hour Care	H0011	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)
Out-of-Home Residential	Clinically Managed 24-hour Care	H0013	Alcohol and/or drug services; acute detoxification (residential addiction program outpatient)
Out-of-Home Residential	Clinically managed medium intensity care	H0010	Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient)
Out-of-Home Residential	Clinically managed medium intensity care	H0012	Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)
Out-of-Home Residential	Crisis residential stabilization services	S9485	Crisis intervention mental health services; per diem
Out-of-Home Residential	Crisis residential stabilization services	T2034	Crisis intervention, waiver; per diem
Out-of-Home Residential	Residential	90817	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services

Out-of-Home Residential	Residential Services	90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 20 to 30 minutes face-to-face with the patient (one unit maximum per session)
Out-of-Home Residential	Residential Services	90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 45 to 50 minutes face-to-face with the patient
Out-of-Home Residential	Residential Services	90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 75 to 80 minutes face-to-face with the patient
Out-of-Home Residential	Residential Services	90822	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
Out-of-Home Residential	Residential Services	H0017	Behavioral health; residential (hospital residential treatment program), without room and board; per diem
Out-of-Home Residential	Residential Services	H0018	Behavioral health; short-term residential (non hospital residential treatment program), without room and board; per diem
Out-of-Home Residential	Residential Services	H0019	Behavioral health; long term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board; per diem
Out-of-Home Residential	Residential Services	H2036	Alcohol and/or other drug treatment program; per diem

Out-of-Home Residential	Residential Services	T2048	Behavioral health; long-term care residential (non-acute care in a residential treatment program where stay is typically longer than 30 days), with room and board; per diem
Out-of-Home Residential	Therapeutic Foster Care	S5145	Foster care, therapeutic, child; per diem
Out-of-Home Residential	Therapeutic Foster Care	S5146	Foster care, therapeutic, child; per month
ACUTE INTENSIVE SERVICES			
Acute Intensive services	24/7 Crisis Hotline Service	H0030	Behavioral health hotline service
Acute Intensive Services	Crisis stabilization	S9485	Crisis intervention mental health services; per diem
Acute Intensive Services	Medically monitored intensive Inpatient	90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 20 to 30 minutes face-to-face with the patient (one unit maximum per session)
Acute Intensive Services	Medically monitored intensive Inpatient	90817	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
Acute Intensive Services	Medically monitored intensive Inpatient	90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 45 to 50 minutes face-to-face with the patient

Acute Intensive Services	Medically monitored intensive Inpatient	90819	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
Acute Intensive Services	Medically monitored intensive Inpatient	90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 75 to 80 minutes face-to-face with the patient
Acute Intensive Services	Medically monitored intensive Inpatient	90822	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
Acute Intensive Services	Medically monitored intensive Inpatient	90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital or residential care setting, approximately 20 to 30 minutes face-to-face
Acute Intensive Services	Medically monitored intensive Inpatient	90824	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face

Acute Intensive Services	Medically monitored intensive Inpatient	90827	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face
Acute intensive services	Medically monitored intensive inpatient	H0009	Alcohol and/or drug services; acute detoxification (hospital inpatient)
Acute intensive services	Medically monitored intensive inpatient	S9475	Ambulatory setting substance abuse treatment or detoxification services; per diem
Acute Intensive services	Medically monitored intensive inpatient	T2044	Hospice inpatient respite care; per diem
Acute Intensive Services	Mobile Crisis Services	H0007	Alcohol and/or drug services; crisis intervention (outpatient)
Acute intensive services	Mobile Crisis Services	H2011	Crisis Intervention Services; per 15 Minutes
Acute intensive services	Mobile Crisis Services	S9484	Crisis intervention mental health services; per hour
Acute intensive services	Urgent Care Services	S9083	Global fee urgent care centers
Acute intensive services	Urgent Care Services	S9088	Services provided in an urgent care center (list in addition to code for service)
Acute intensive services	Peer based Crisis Services	N/A	May use crisis service codes with provider type if approriate
RECOVERY SUPPORTS			
Recovery Supports	Peer Supports	H0038	Self-help/peer services; per 15 minutes
Recovery Supports	Recovery Support Coaching	G0409	Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals
Recovery Supports	Recovery Support Services: Self Directed Care	T2040	Financial management, self-directed, waiver; per 15 minutes
Recovery Supports	Recovery Support Services: Self Directed Care	T2041	Supports brokerage, self-directed, waiver; per 15 minutes
Recovery Supports	Recovery Support Center Services	N/A	Use appropriate service code with provider type if appropriate
Recovery Supports	Continuing Care for SUD	N/A	Use appropriate service code

Exhibit:	I	Created:	11/29/2011
Name:	Mental Health Evidence Based Practices Definitions	Last Revised:	
Reports:	101		

MENTAL HEALTH EVIDENCE BASED PRACTICE DEFINITIONS

Supported Housing
Procedure Codes found in Exhibit H: H0043, H0044
"Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assist clients to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation.

Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities, criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), right to tenure, service choice, service individualization and service availability.

Supported Employment
Procedure Codes found in Exhibit H: H2023, H2024, H2025, H2026
Mental Health Supported Employment (SE) is an evidence-based service to promote rehabilitation and return to productive employment for persons with serious mental illness' rehabilitation and their return to productive employment. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client:staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

Assertive Community Treatment

Procedure Codes found in Exhibit H: H0039, H0040
A team based approach to the provision of treatment, rehabilitation and support services. ACT/PACT models of treatment are built around a self-contained multi-disciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. A key aspect are low caseloads and the availability of the services in a range of settings. The service is a recommended practice in the PORT study (Translating Research Into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations, Lehman, Steinwachs and Co-Investigators of Patient Outcomes Research Team, Schizophrenia Bulletin, 24(1):1-10, 1998) and is cited as a practice with strong evidence based on controlled, randomizaed effectiveness studies in the Surgeon General's report on mental health (Mental Health: A Report of the Surgeon General, December, 1999, Chapter 4, ""Adults and Mental Health, Service Delivery, Assertive Community Treatment""). Additionally, HCFA recommended that state Medicaid agencies consider adding the service to their State Plans in HCFA Letter to State Medicaid Directors, Center for Medicaid and State Operations , June 07, 1999.

Peer Support - Adult Mental Health
Procedure Codes found in Exhibit H: H0038
Services provided by a Kentucky Peer Specialist (KPS) (as defined in 908 KAR 2:220) to assist adults with serious mental illness (SMI) in achieving specific recovery goals.

Integrated Treatment for Co-occurring Disorders
Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.

Illness Self-Management
Illness Self-Management (also called illness management or wellness management): Is a broad set of rehabilitation methods aimed at teaching individuals with mental illness strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and rehospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psychoeducation about the nature of mental illness and its treatment, "behavioral tailoring"" to help individuals incorporate the taking of

medication into their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.

Medication Management
Procedure Codes found in Exhibit H: H0034, H2010, 90862
In the toolkit on medication management there does not appear to be any explicit definition of medication management. However the critical elements identified for evidence-based medication management approaches are the following:

1. Utilization of a systematic plan for medication management
2. Objective measures of outcome are produced
3. Documentation is thorough and clear
4. Consumers and practitioners share in the decision-making

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emotional and social competence and to prevent, reduce, and treat behavioral and emotional problems in young children.

Parent Child Interaction Therapy
Procedure Codes found in Exhibit H: 90847
Parent-Child Interaction Therapy (PCIT) is a treatment program for young children with conduct disorders that emphasize improving the quality of the parent-child relationship and changing parent-child interaction patterns. PCIT was developed for children ages 2-7 years with externalizing behavior disorders.

Cognitive Behavioral Therapies
Procedure Codes found in Exhibit H: 90807
Those therapies that emphasize the use of both behavior and cognitive techniques to change the way an individual thinks about him/herself (eg. Trauma-focused Cognitive Behavioral Therapy, Cognitive Behavioral Therapy for Depression, Cognitive Behavioral Therapy for Anxiety, etc.).

Wraparound
Procedure Codes found in Exhibit H: H2022
Wraparound is a promising practice designed to provide a set of individually tailored services to the child and family through a sound planning process that is community based and focused on strengths. The wraparound approach is team driven (family, child, natural supports, agencies, and community services) where families must be active partners and the supports put in place provide a balance between formal services and informal community and family supports and is provided with the assistance of Wraparound Facilitators or Service Coordinators.

Trauma Screening
Use a standardized (valid and reliable) screening tool that focuses specifically on screening for trauma symptoms and trauma-related conditions (e.g. Trauma Symptom Inventory, Trauma Symptom Checklist for Children/Young Children, Children's Impact of Traumatic Events Scale, Children's PTSD Inventory, etc.).

Exhibit:	J	Created:	12/06/2011
Name:	BHDID Psychotropic Medication Class Codes	Last Revised:	12/09/2011
Reports:	106		

Psychotropic Medication Class	BHDID Med class code

Antianxiety	
Antianxiety Benzodiazepines	021
Antianxiety Non-Benzodiazepines	029
Antidepressants	
Antidepressants MAOs	031
Antidepressants SNRIs	032
Antidepressants SSRIs	033
Antidepressants Tricyclics	034
Antidepressants Other (e.g. Tetracyclics)	039
Antipsychotics	
Antipsychotic Atypicals	041
Antipsychotic Typicals	042
CNS Stimulants	050
Mood Stabilizers	060
Substance Abuse Med	070
Other Psychotropic (e.g., Clonidine)	090

Exhibit:	K	Created:	12/12/2011
Name:	Behavioral Health and Chronic Physical Health	Last Revised:	
Reports:	102		

ICD-9-CM CODE'	Dx CATEGORY DESCRIPTION'	'ICD-9-CM CODE DESCRIPTION'
	CENTRAL NERVOUS SYSTEM	
Dementia		
'2900 '	'Delirium/dementia/amnestic/other cognitiv'	SENILE DEMENTIA UNCOMP
'29010'	'Delirium/dementia/amnestic/other cognitiv'	PRESENILE DEMENTIA
'29011'	'Delirium/dementia/amnestic/other cognitiv'	PRESENILE DELIRIUM
'29012'	'Delirium/dementia/amnestic/other cognitiv'	PRESENILE DELUSION
'29013'	'Delirium/dementia/amnestic/other cognitiv'	PRESENILE DEPRESSION
'29020'	'Delirium/dementia/amnestic/other cognitiv'	SENILE DELUSION
'29021'	'Delirium/dementia/amnestic/other cognitiv'	SENILE DEPRESSIVE
'2903 '	'Delirium/dementia/amnestic/other cognitiv'	SENILE DELIRIUM
'29040'	'Delirium/dementia/amnestic/other cognitiv'	ARTERIOSCLER DEMENT NOS
'29041'	'Delirium/dementia/amnestic/other cognitiv'	ARTERIOSCLER DELIRIUM
'29042'	'Delirium/dementia/amnestic/other cognitiv'	ARTERIOSCLER DELUSION
'29043'	'Delirium/dementia/amnestic/other cognitiv'	ARTERIOSCLER DEPRESSIVE
'2908 '	'Delirium/dementia/amnestic/other cognitiv'	SENILE PSYCHOSIS NEC
'2909 '	'Delirium/dementia/amnestic/other cognitiv'	SENILE PSYCHOT COND NOS
'2930 '	'Delirium/dementia/amnestic/other cognitiv'	ACUTE DELIRIUM
'2931 '	'Delirium/dementia/amnestic/other cognitiv'	SUBACUTE DELIRIUM
'2940 '	'Delirium/dementia/amnestic/other cognitiv'	AMNESTIC SYNDROME

'2941 '	'Delirium/dementia/amnestic/other cognitiv'	DEMENTIA IN OTH DISEASES
'29410'	'Delirium/dementia/amnestic/other cognitiv'	DEMENTIA IN OTH DISEASES W0 BEHAVRAL OCT00-
'29411'	'Delirium/dementia/amnestic/other cognitiv'	DEMENTIA IN OTH DISEASES WBEHAVIORAL OCT00-
'29420'	'Delirium/dementia/amnestic/other cognitiv'	Demen NOS w/o behv dstrb (Begin 2011)
'29421'	'Delirium/dementia/amnestic/other cognitiv'	Demen NOS w behav distrb (Begin 2011)
'2948 '	'Delirium/dementia/amnestic/other cognitiv'	ORGANIC BRAIN SYND NEC
'2949 '	'Delirium/dementia/amnestic/other cognitiv'	ORGANIC BRAIN SYND NOS
'3100 '	'Delirium/dementia/amnestic/other cognitiv'	FRONTAL LOBE SYNDROME
'3102 '	'Delirium/dementia/amnestic/other cognitiv'	POSTCONCUSSION SYNDROME
'3108 '	'Delirium/dementia/amnestic/other cognitiv'	NONPSYCHOT BRAIN SYN NEC (end 2011)
'31081'	'Delirium/dementia/amnestic/other cognitiv'	Pseudobulbar affect (Begin 2011)
'31089'	'Delirium/dementia/amnestic/other cognitiv'	Nonpsych mntl disord NEC (Begin 2011)
'3109 '	'Delirium/dementia/amnestic/other cognitiv'	NONPSYCHOT BRAIN SYN NOS
'3310 '	'Delirium/dementia/amnestic/other cognitiv'	ALZHEIMERS DISEASE
'3311 '	'Delirium/dementia/amnestic/other cognitiv'	FRONTOTEMPORAL DEMENTIA
'33111'	'Delirium/dementia/amnestic/other cognitiv'	PICKS DISEASE
'33119'	'Delirium/dementia/amnestic/other cognitiv'	OTHER FRONTOTEMPORAL DEMENTIA
'3312 '	'Delirium/dementia/amnestic/other cognitiv'	SENILE DEGENERAT BRAIN
'33182'	'Delirium/dementia/amnestic/other cognitiv'	DEMENTIA WITH LEWY BODIES
'797 '	'Delirium/dementia/amnestic/other cognitiv'	SENILITY WITHOUT MENTION OF PSYCHOSIS
Parkinson's		
'3320 '	'Parkinson-s'	PARALYSIS AGITANS
'3321 '	'Oth nerv dx'	SECONDARY PARKINSONISM
Seizure Disorders		
'34500'	'Epilepsy/cnv'	GEN NONCV EP W/O INTR EP (Begin 1989)
'34501'	'Epilepsy/cnv'	GEN NONCONV EP W INTR EP (Begin 1989)
'34510'	'Epilepsy/cnv'	GEN CNV EPIL W/O INTR EP (Begin 1989)
'34511'	'Epilepsy/cnv'	GEN CNV EPIL W INTR EPIL (Begin 1989)
'3452 '	'Epilepsy/cnv'	PETIT MAL STATUS

'3453 '	'Epilepsy/cnv'	GRAND MAL STATUS
'34570'	'Epilepsy/cnv'	EPIL PAR CONT W/O INT EP (Begin 1989)
'34571'	'Epilepsy/cnv'	EPIL PAR CONT W INTR EPI (Begin 1989)
'34580'	'Epilepsy/cnv'	EPILEP NEC W/O INTR EPIL (Begin 1989)
'34581'	'Epilepsy/cnv'	EPILEPSY NEC W INTR EPIL (Begin 1989)
'34590'	'Epilepsy/cnv'	EPILEP NOS W/O INTR EPIL (Begin 1989)
'34591'	'Epilepsy/cnv'	EPILEPSY NOS W INTR EPIL (Begin 1989)
'78033'	'Epilepsy/cnv'	Post traumatic seizures (Begin 2010)
'78039'	'Epilepsy/cnv'	OT CONVULSIONS (Begin 1997)
CARDIOVASCULAR DISEASE		
Myocardial Infarction		
'41000'	'Acute MI'	AMI ANTEROLATERAL;UNSPEC (Begin 1989)
'41001'	'Acute MI'	AMI ANTEROLATERAL- INIT (Begin 1989)
'41002'	'Acute MI'	AMI ANTEROLATERAL;SUBSEQ (Begin 1989)
'41010'	'Acute MI'	AMI ANTERIOR WALL;UNSPEC (Begin 1989)
'41011'	'Acute MI'	AMI ANTERIOR WALL- INIT (Begin 1989)
'41012'	'Acute MI'	AMI ANTERIOR WALL;SUBSEQ (Begin 1989)
'41020'	'Acute MI'	AMI INFEROLATERAL;UNSPEC (Begin 1989)
'41021'	'Acute MI'	AMI INFEROLATERAL- INIT (Begin 1989)
'41022'	'Acute MI'	AMI INFEROLATERAL;SUBSEQ (Begin 1989)
'41030'	'Acute MI'	AMI INFEROPOST- UNSPEC (Begin 1989)
'41031'	'Acute MI'	AMI INFEROPOST- INITIAL (Begin 1989)
'41032'	'Acute MI'	AMI INFEROPOST- SUBSEQ (Begin 1989)
'41040'	'Acute MI'	AMI INFERIOR WALL;UNSPEC (Begin 1989)
'41041'	'Acute MI'	AMI INFERIOR WALL- INIT (Begin 1989)
'41042'	'Acute MI'	AMI INFERIOR WALL;SUBSEQ (Begin 1989)
'41050'	'Acute MI'	AMI LATERAL NEC- UNSPEC (Begin 1989)
'41051'	'Acute MI'	AMI LATERAL NEC- INITIAL (Begin 1989)

'41052'	'Acute MI'	AMI LATERAL NEC- SUBSEQ (Begin 1989)
'41060'	'Acute MI'	TRUE POST INFARCT;UNSPEC (Begin 1989)
'41061'	'Acute MI'	TRUE POST INFARCT- INIT (Begin 1989)
'41062'	'Acute MI'	TRUE POST INFARCT;SUBSEQ (Begin 1989)
'41070'	'Acute MI'	SUBENDO INFARCT- UNSPEC (Begin 1989)
'41071'	'Acute MI'	SUBENDO INFARCT- INITIAL (Begin 1989)
'41072'	'Acute MI'	SUBENDO INFARCT- SUBSEQ (Begin 1989)
'41080'	'Acute MI'	AMI NEC- UNSPECIFIED (Begin 1989)
'41081'	'Acute MI'	AMI NEC- INITIAL (Begin 1989)
'41082'	'Acute MI'	AMI NEC- SUBSEQUENT (Begin 1989)
'41090'	'Acute MI'	AMI NOS- UNSPECIFIED (Begin 1989)
'41091'	'Acute MI'	AMI NOS- INITIAL (Begin 1989)
'41092'	'Acute MI'	AMI NOS- SUBSEQUENT (Begin 1989)
Hypertension		
'4011 '	'HTN'	BENIGN HYPERTENSION
'4019 '	'HTN'	HYPERTENSION NOS
'4010 '	'Htn complicn'	MALIGNANT HYPERTENSION
'40200'	'Htn complicn'	MAL HYPERTEN HRT DIS NOS
'40201'	'Htn complicn'	MAL HYPERT HRT DIS W CHF
'40210'	'Htn complicn'	BEN HYPERTEN HRT DIS NOS
'40211'	'Htn complicn'	BENIGN HYP HRT DIS W CHF
'40290'	'Htn complicn'	HYPERTENSIVE HRT DIS NOS
'40291'	'Htn complicn'	HYPERTEN HEART DIS W CHF
'40300'	'Htn complicn'	MAL HYP REN W/O REN FAIL (Begin 1989)
'40301'	'Htn complicn'	MAL HYP REN W RENAL FAIL (Begin 1989)
'40310'	'Htn complicn'	BEN HYP REN W/O REN FAIL (Begin 1989)
'40311'	'Htn complicn'	BEN HYP RENAL W REN FAIL (Begin 1989)
'40390'	'Htn complicn'	HYP REN NOS W/O REN FAIL (Begin 1989)
'40391'	'Htn complicn'	HYP RENAL NOS W REN FAIL (Begin 1989)
'40400'	'Htn complicn'	MAL HY HT/REN W/O CHF/RF (Begin 1989)

'40401'	'Htn complicn'	MAL HYPER HRT/REN W CHF (Begin 1989)
'40402'	'Htn complicn'	MAL HY HT/REN W REN FAIL (Begin 1989)
'40403'	'Htn complicn'	MAL HYP HRT/REN W CHF & RF (Begin 1989)
'40410'	'Htn complicn'	BEN HY HT/REN W/O CHF/RF (Begin 1989)
'40411'	'Htn complicn'	BEN HYPER HRT/REN W CHF (Begin 1989)
'40412'	'Htn complicn'	BEN HY HT/REN W REN FAIL (Begin 1989)
'40413'	'Htn complicn'	BEN HYP HRT/REN W CHF & RF (Begin 1989)
'40490'	'Htn complicn'	HY HT/REN NOS W/O CHF/RF (Begin 1989)
'40491'	'Htn complicn'	HYPER HRT/REN NOS W CHF (Begin 1989)
'40492'	'Htn complicn'	HY HT/REN NOS W REN FAIL (Begin 1989)
'40493'	'Htn complicn'	HYP HT/REN NOS W CHF & RF (Begin 1989)
'40501'	'Htn complicn'	MAL RENOVASC HYPERTENS
'40509'	'Htn complicn'	MAL SECOND HYPERTEN NEC
'40511'	'Htn complicn'	BENIGN RENOVASC HYPERTEN
'40519'	'Htn complicn'	BENIGN SECOND HYPERT NEC
'40591'	'Htn complicn'	RENOVASC HYPERTENSION
'40599'	'Htn complicn'	SECOND HYPERTENSION NEC
'4372 '	'Htn complicn'	HYPERTENS ENCEPHALOPATHY
Coronary Atherosclerosis		
'4110 '	'Coron athero'	POST MI SYNDROME
'4111 '	'Coron athero'	INTERMED CORONARY SYND
'41181'	'Coron athero'	CORONARY OCCLSN W/O MI (Begin 1989)
'41189'	'Coron athero'	AC ISCHEMIC HRT DIS NEC (Begin 1989)
'412 '	'Coron athero'	OLD MYOCARDIAL INFARCT
'4130 '	'Coron athero'	ANGINA DECUBITUS
'4131 '	'Coron athero'	PRINZMETAL ANGINA
'4139 '	'Coron athero'	ANGINA PECTORIS NEC/NOS
'41400'	'Coron athero'	CORONARY ATHERO NOS (Begin 1994)
'41401'	'Coron athero'	CORONARY ATHERO NATIVE VESSEL (Begin 1994)

'41406'	'Coron athero'	CORONARY ATHERO CRNRY ARTERY OF TRANS (Begin 2002)
'4142 '	'Coron athero'	CHR TOT OCCLUS COR ARTRY (Begin 2007)
'4143 '	'Coron athero'	COR ATH D/T LPD RCH PLAQ (Begin 2008)
'4144 '	'Coron athero'	Cor ath d/t calc cor lsn (Begin 2011)
'4148 '	'Coron athero'	CHR ISCHEMIC HRT DIS NEC
'4149 '	'Coron athero'	CHR ISCHEMIC HRT DIS NOS
'V4581'	'Coron athero'	AORTOCORONARY BYPASS
'V4582'	'Coron athero'	PTCA STATUS (Begin 1994)
Heart Failure		
'4280 '	'chf;nonhp'	CONGESTIVE HEART FAILURE
'4281 '	'chf;nonhp'	LEFT HEART FAILURE
'42820'	'chf;nonhp'	UNSPECIFIED SYSTOLIC HEART FAILURE (Begin 2002)
'42821'	'chf;nonhp'	ACUTE SYSTOLIC HEART FAILURE (Begin 2002)
'42822'	'chf;nonhp'	CHRONIC SYSTOLIC HEART FAILURE (Begin 2002)
'42823'	'chf;nonhp'	ACUTE ON CHRONIC SYSTOLIC HEART FAILR (Begin 2002)
'42830'	'chf;nonhp'	UNSPECIFIED DIASTOLIC HEART FAILURE (Begin 2002)
'42831'	'chf;nonhp'	ACUTE DIASTOLIC HEART FAILURE (Begin 2002)
'42832'	'chf;nonhp'	CHRONIC DIASTOLIC HEART FAILURE (Begin 2002)
'42833'	'chf;nonhp'	ACUTE ON CHRONIC DIASTOLIC HEART FAILR (Begin 2002)
'42840'	'chf;nonhp'	UNSPEC CMBINED SYST & DIAS HEART FAILR (Begin 2002)
'42841'	'chf;nonhp'	ACUTE CMBINED SYST & DIAS HEART FAILR (Begin 2002)
'42842'	'chf;nonhp'	CHRON CMBINED SYST & DIAS HEART FAILR (Begin 2002)
'42843'	'chf;nonhp'	ACU CHRO COMBI SYST & DIAS HRT FAILR (Begin 2002)
'4289 '	'chf;nonhp'	HEART FAILURE NOS
Stroke		
'V1254'	'Ot circul dx'	HX TIA/STROKE W/O RESID (Begin 2007)
'436 '	'Acute CVD'	CVA
'34660'	'Acute CVD'	PRS ARA W INF WO NTR/ST (Begin 2008)
'34661'	'Acute CVD'	PRS ARA W/INF/NTR WO ST (Begin 2008)

'34662'	'Acute CVD'	PRS ARA WO NTR W INF/ST (Begin 2008)
'34663'	'Acute CVD'	PRST ARA W INF W NTR/ST (Begin 2008)
'430 '	'Acute CVD'	SUBARACHNOID HEMORRHAGE
'431 '	'Acute CVD'	INTRACEREBRAL HEMORRHAGE
'4320 '	'Acute CVD'	NONTRAUM EXTRADURAL HEM
'4321 '	'Acute CVD'	SUBDURAL HEMORRHAGE
'4329 '	'Acute CVD'	INTRACRANIAL HEMORR NOS
'43301'	'Acute CVD'	BASILAR ART OCCLUS W/CEREB INFARCT (Begin 1993)
'43311'	'Acute CVD'	CAROTID ART OCCLUS W/CEREB INFARCT (Begin 1993)
'43321'	'Acute CVD'	VERTEB ART OCCLUS W/CEREB INFARCT (Begin 1993)
'43331'	'Acute CVD'	MULT PRECEREB OCCLUS W/ INFARCT (Begin 1993)
'43381'	'Acute CVD'	PRECEREB OCCLUSION NEC W/ INFARCT (Begin 1993)
'43391'	'Acute CVD'	PRECEREB OCCLUS NOS W/O INFARCT (Begin 1993)
'43400'	'Acute CVD'	CEREB THROMBOSIS W/O INFARCT (Begin 1993)
'43401'	'Acute CVD'	CEREB THROMBOSIS W/ INFARCTION (Begin 1993)
'43410'	'Acute CVD'	CEREB EMBOLISM W/O INFARCTION (Begin 1993)
'43411'	'Acute CVD'	CEREB EMBOLISM W/ INFARCTION (Begin 1993)
'43490'	'Acute CVD'	CEREBR ART OCCLUS NOS W/O INFARCT (Begin 1993)
'43491'	'Acute CVD'	CEREBR ART OCCLUS NOS W/ INFARCT (Begin 1993)
RESPIRATORY DISEASE		
Asthma		
'49300'	'Asthma'	EXT ASTHMA W/O STAT ASTH
'49301'	'Asthma'	EXT ASTHMA W STATUS ASTH
'49302'	'Asthma'	EXT ASTHMA W/ ACUTE EXACERBATION (Begin 2000)
'49310'	'Asthma'	INT ASTHMA W/O STAT ASTH
'49311'	'Asthma'	INT ASTHMA W STATUS ASTH
'49312'	'Asthma'	INT ASTHMA W/ ACUTE EXACERBATION (Begin 2000)
'49320'	'Asthma'	CH OB ASTH W/O STAT ASTH (Begin 1989)

'49321'	'Asthma'	CH OB ASTHMA W STAT ASTH (Begin 1989)
'49322'	'Asthma'	CH OB ASTHMA W/ACUTE EXACERBATION (Begin 2000)
'49381'	'Asthma'	EXERCISE INDUCED BRONCHOSPASM (Begin 2003)
'49382'	'Asthma'	COUGH VARIANT ASTHMA (Begin 2003)
'49390'	'Asthma'	ASTHMA W/O STATUS ASTHM
'49391'	'Asthma'	ASTHMA W/ STATUS ASTHMAT
'49392'	'Asthma'	ASTHMA W/ ACUTE EXACERBATION (Begin 2000)
COPD		
'490 '	'COPD'	BRONCHITIS NOS
'4910 '	'COPD'	SIMPLE CHR BRONCHITIS
'4911 '	'COPD'	MUCOPURUL CHR BRONCHITIS
'49120'	'COPD'	OBS CHR BRNC W/O ACT EXA (Begin 1991)
'49121'	'COPD'	OBS CHR BRNC W ACT EXA (Begin 1991)
'49122'	'COPD'	OBS CHR BRONC W AC BRONC (Begin 2004)
'4918 '	'COPD'	CHRONIC BRONCHITIS NEC
'4919 '	'COPD'	CHRONIC BRONCHITIS NOS
'4920 '	'COPD'	EMPHYSEMATOUS BLEB
'4928 '	'COPD'	EMPHYSEMA NEC
'4940 '	'COPD'	BRONCHIECTASIS W/O ACUTE EXACERBATN (Begin 2000)
'4941 '	'COPD'	BRONCHIECTASIS W/ACUTE EXACERBATION (Begin 2000)
'496 '	'COPD'	CHR AIRWAY OBSTRUCT NEC
ENDOCRINE SYSTEM		
Diabetes		
'25000'	'DiabMel no c'	DIABETES UNCOMPL TYPE II
'25001'	'DiabMel no c'	DIABETES UNCOMPL TYPE I
'25002'	'DiabMel w/cm'	DIABETES MELL TYPE II UNCONT (Begin 1993)
'25003'	'DiabMel w/cm'	DIABETES MELL TYPE I UNCONT (Begin 1993)
'2535 '	'Ot endo dsor'	DIABETES INSIPIDUS

	OTHER	
Obesity		
'27800'	'Ot nutrit dx'	OBESITY UNSPECIFIED (Begin 1995)
'27801'	'Ot nutrit dx'	MORBID OBESITY (Begin 1995)
Hearing Loss		
'38900'	'Other ear dx'	CONDUCT HEARING LOSS NOS
'38901'	'Other ear dx'	CONDUC HEAR LOSS EXT EAR
'38902'	'Other ear dx'	CONDUCT HEAR LOSS TYMPAN
'38903'	'Other ear dx'	CONDUC HEAR LOSS MID EAR
'38904'	'Other ear dx'	COND HEAR LOSS INNER EAR
'38905'	'Other ear dx'	CONDCTV HEAR LOSSUNILAT (Begin 2007)
'38906'	'Other ear dx'	CONDCTV HEAR LOSS BILAT (Begin 2007)
'38908'	'Other ear dx'	COND HEAR LOSS COMB TYPE
'38910'	'Other ear dx'	SENSORNEUR HEAR LOSS NOS
'38911'	'Other ear dx'	SENSORY HEARING LOSS
'38912'	'Other ear dx'	NEURAL HEARING LOSS
'38913'	'Other ear dx'	NEURAL HEAR LOSS UNILAT (Begin 2007)
'38914'	'Other ear dx'	CENTRAL HEARING LOSS
'38915'	'Other ear dx'	SENSORNEUR HEAR LOSS UNI (Begin 2006)
'38916'	'Other ear dx'	SENSONEUR HEAR LOSS ASYM (Begin 2006)
'38917'	'Other ear dx'	SENSORY HEAR LOSSUNILAT (Begin 2007)
'38918'	'Other ear dx'	SENSORNEUR LOSS COMB TYP
'38920'	'Other ear dx'	MIXED HEARING LOSS NOS (Begin 2007)
'38921'	'Other ear dx'	MIXED HEARING LOSSUNILT (Begin 2007)
'38922'	'Other ear dx'	MIXED HEARING LOSSBILAT (Begin 2007)
'3897 '	'Other ear dx'	DEAF MUTISM NEC
'3898 '	'Other ear dx'	HEARING LOSS NEC

'3899 '	'Other ear dx'	HEARING LOSS NOS
'V412 '	'Other ear dx'	PROBLEMS WITH HEARING
'V413 '	'Other ear dx'	EAR PROBLEMS NEC
'V4985'	'Other ear dx'	DUAL SENSORY IMPAIRMENT (Begin 2007)
'V532 '	'Other ear dx'	ADJUSTMENT HEARING AID
'V721 '	'Other ear dx'	EAR & HEARING EXAM
'V7211'	'Other ear dx'	HEARING EXAM-FAIL SCREEN (Begin 2006)
'V7212'	'Other ear dx'	HEARING CONSERVATN/TRTMT (Begin 2007)
'V7219'	'Other ear dx'	EXAM EARS & HEARING NEC (Begin 2006)

Appendix L - 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 M - 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	Clinical	YES	NO	YES	YES	The data on emergency room utilization of FFS

Department (ED) Use Management	Care					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 N - 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®)[1] 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).

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

Healthy Kentuckians Leading Health Indicator(s)[2]	Healthy Kentuckians Goals	Health Kentuckians Objectives[3]	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[4] ▪ Height/Weight/BMI Assessment and Assessment/ Counseling for Nutrition and Physical Activity for Children and Adolescents[5]

[2] 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.

[3] 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.

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

[5] 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)[2]	Healthy Kentuckians Goals	Health Kentuckians Objectives[3]	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)[2]	Healthy Kentuckians Goals	Health Kentuckians Objectives[3]	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[6]

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

Healthy Kentuckians Leading Health Indicator(s)[2]	Healthy Kentuckians Goals	Health Kentuckians Objectives[3]	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)[2]	Healthy Kentuckians Goals	Health Kentuckians Objectives[3]	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[7]
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[8] ▪ HEDIS Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life

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

[8] 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)[2]	Healthy Kentuckians Goals	Health Kentuckians Objectives[3]	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[9], 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

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

Healthy Kentuckians Leading Health Indicator(s)[2]	Healthy Kentuckians Goals	Health Kentuckians Objectives[3]	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)[2]	Healthy Kentuckians Goals	Health Kentuckians Objectives[3]	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[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.	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	

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

Healthy Kentuckians Leading Health Indicator(s)[2]	Healthy Kentuckians Goals	Health Kentuckians Objectives[3]	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 O - 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 P - 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

FY 20XX Monitoring Tool
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