27. Contractor Reporting Requirements (Section 37.0 Contractor Reporting Requirement)

a. As indicated in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," the Department would like to leverage the contracted MCOs existing technologies and reporting capabilities to develop a comprehensive reporting package through a collaborative process. Understanding that ultimately the Department will define the reporting package, describe the Contractor's willingness to participate in such a collaboration, including a discussion of the following:

UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) is looking forward to participating in a collaborative process with DMS to apply the best of our technologies and reporting capabilities from our 31 state partners plus the District of Columbia. In our experience working with our state partners, the result of this type of collaboration provides a strong foundation for success. We have successfully participated in such collaboration in several states such as Florida, Kansas and Arizona and have provided more information on these collaborations in the following paragraphs. We agree to comply with all reporting requirements described in Attachment C – Draft Medicaid Managed Care Contract, Section 37.0 Contractor Reporting Requirements.

i. Proposed reports and report templates that will result in a comprehensive, Department-accepted reporting package.

Please refer to Attachment C.27.a.i for our sample reporting templates and reports. We have provided a broad range of proposed reports and report templates as a foundation for our collaboration with DMS. We believe that the sample reports we have provided demonstrate current reporting capabilities in areas of interest to DMS. Among others, they include:

- Grievances and Appeals
- Pharmacy Drug Utilization Review (DUR) Program
- EPSDT Participation Monthly/Quarterly
- Initial Care Needs Screening
- Opioid Misuse and Prevention
- Fraud, Waste and Abuse
- Call Service Line Metrics Analysis

ii. Proposed ideas for collaborating across MCOs to ensure consistent and comparable reporting using the same data definitions and specification can be achieved.

From our experience collaborating with MCOs in the past, our recommendation is to form a reporting workgroup consisting of reporting subject matter experts (SMEs) from all MCOs that meet regularly in Kentucky upon contract award. The focus of the workgroup will be to work collaboratively to define the specific measures that will ultimately be described in DMS's comprehensive and comparable reporting package. The MCO reporting workgroup will work with DMS to enhance and further develop reporting that is effective, useful and supports overall MCO program goals.

Through our partnerships with Medicaid managed care programs across the country, we can provide the experienced staff and robust technologies to allow efficient reporting flexibility that is often needed in a new managed care program. For example:

- ***KanCare Medicaid Program:*** When we implemented the KanCare Medicaid program in Kansas, we collaborated with the State Medicaid agency (KDHE) to develop a robust suite of reports across a wide range of functions. As the program evolved, our reporting

teams collaborated with the KDHE to redesign financial reconciliation reporting templates to better allow comparison across MCOs and categories of service. In response to requests from the legislature and governor, we collaborated with KDHE and other agencies to produce a range of data for various regulatory and legislative meetings, including the program's oversight committee, along with other legislative committees.

- ■ **Florida AHCA:** We partner with and support two different AHCA factions (FL AHCA ASR Team/FL AHCA MMIS Team) ensuring reporting and requirements remain in sync to include State Specific Category of Service. All MCOs shared this requirement to allow program oversight and better comparisons. These reports also carry a requirement to tie to our financial and encounter systems within a 2% variance. We also provided technical support when working with the MMIS team on their category of service logic within their system to be in alignment with what UnitedHealthcare was providing.

- ■ **Arizona Association of Health Plans:** When the Arizona Association of Health Plans (AzAHP) launched an initiative to reduce the burden of credentialing placed on Arizona physicians, we participated in the development and deployment of a statewide credentialing alliance, working with other state Medicaid partners as a member of the AzAHP. This effort was a useful strategy for alignment of credentialing cycles across all Arizona Medicaid plans, reduced duplication of efforts and provided for administrative simplification. The final Arizona Alliance Plan became operational in October 2012 and it is in use today.

Our reporting team will review all MCO program reports prior to submission to confirm completeness and accuracy. This includes a review and attestation performed by the functional lead of the area affected by the report. Our Business Analytics Sciences Insights & Strategy (BASIS) team will work with the reporting team and our health plan compliance officer to confirm that regulatory reports and audits are supported timely, completely, accurately and with complete documentation. The team is a dedicated resource and well versed in the expectations of contractual reporting expected in the execution of state Medicaid contracts.

We will submit all reports to DMS, according Section 37.0 Contractor Reporting Requirements and DMS direction. Our team will submit reports via electronic channels or other formats as required, and confirm that all reports are complete and accurate.

iii. Requirement of Subcontractors to participate and or comply with this process.

We require our subcontractors to participate and comply with our reporting process. For over a decade at the national level, we have garnered a substantial amount of information on working with subcontractors and integrating their services into our programs — and we have learned how to do this successfully. We have used this knowledge to improve our subcontractor processes to strengthen our programs and to offer seamless, well-integrated services for our enrollees and providers. We work alongside internal affiliate and external subcontractors with whom we have strong, well-established relationships. Our vendor relations manager verifies that we receive all required data, especially encounter data, from our subcontractors as scheduled and in alignment with data integrity.

For additional information on how we monitor, report and track subcontractor data, please see our response to Question 27.e.

b. Provide a detailed description of the Contractor's capability to produce reports required under this Contract, including an overview of the Contractor's reporting systems and capability to configure such systems to capture data according to reporting definitions and specifications as required by the Department.

UnitedHealthcare confirms that it can produce all required reports within Section 37.0 Contractor Reporting Requirements. With 45 years of experience coordinating care for Medicaid and other public sector programs, we are a trusted partner that is prepared to produce regularly scheduled, on-demand and ad hoc reports effectively for DMS that track Kentucky MCO program performance. Our robust, integrated reporting and data analytics solution enables us to maximize plan effectiveness, meet DMS's reporting requirements, empower providers and care for our enrollees. Our reporting system integrates medical, behavioral, pharmacy, financial, demographic and socioeconomic data to produce all of the reporting and analytics needed to conform to DMS's requirements. This includes predictive analytics, provider information support, FWA and the management of utilization and medical outcomes. Our reporting systems are connected to the data sources across the health plan including but not limited to enrollment and eligibility, provider demographics, claims and utilization management (UM) information.

Our Kentucky MCO program team understands the reporting requirements in the RFP and we will be responsible for meeting DMS's reporting needs. Our local reporting team will participate in the MCO reporting collaboration for Kentucky MCO, with additional support from two national teams:

- *Health Care Economics Team:* This team provides relational data sets, high-level strategic analyses, cost trending and predictive modeling. Using internally developed cutting-edge data evaluative techniques, this team proactively identifies long-term Medicaid program financial viability and beneficial enrollee access opportunities.
- *BASIS Team:* This team is responsible for designing and creating clinical and medical management reports using data from multiple tools, assembling data from various source systems, and providing ad hoc analysis for our health plan.

Accurate, Complete, Timely Reporting

The BASIS team conducts the following functions to confirm accurate and timely report development and submission:

- *Regulatory Reporting Business Requirements Documentation:* Complete and detailed reporting requirements documentation, based upon our requirements, companion guides and discussions for each regulatory report, is produced and loaded into our versioning control system. New requirements and change requests follow this documentation process, so we have a complete document lifecycle of new and changed requirements.
- *Regulatory Reporting Submissions:* Provides the reporting required on time and according to the requirements documentation. New reports follow a strict process of testing, user acceptance testing and analysis of the reports and sign-off. Once we approve a report, we enter it into our automated-production reporting environment and produce it on the schedule requested. An automated report delivery system provides the Kentucky MCO program with the final output location of the reports once the reports have completed their run cycle and have passed internal analysis and validation of the data captured by the report.
- *Regulatory Report Change Control:* Approved reports are placed into our versioning control system. If a change or modification is required, a change control document is created based upon the new requirements, the existing report(s) is checked out of version control, and the development of the changes begins. A test report(s) is provided

for quality assurance, analysis and user acceptance testing to verify the requested changes/modifications have been achieved and the report(s) is true and correct. Once the changes/modifications to the reports are approved, it is checked back into the versioning control system and then follows the process outlined previously for automated production, validation and delivery.

- *Audit Support:* The universe of claims, enrollee and provider data required for any of the regulatory reporting requirements is captured before the run cycle of the reports. Once the reports have been approved and submitted by UnitedHealthcare, the universe of data is exported to remain static.

  - Requests for audit data are handled through our BASIS Support Mailbox (*basis_prog@uhc.com*). Each audit request is supported by the exported universe data for the requested reporting period and elements unless an audit restatement is asked for. Requested audit reporting requirements are fulfilled and provided to the business within reason of the time frame requested.

  - Requests for audit restatement are handled through our BASIS Support Mailbox (*basis_prog@uhc.com*). Each audit restatement request requires a re-pull of the universe of data supporting the submissions and re-reporting the refreshed or restated data. Requested audit reporting requirements are fulfilled and provided to the business within reason of the time frame requested. Once we approve and submit the restatement, data is exported to remain static.

c. Describe the Contractor's processes to review report accuracy and completeness prior to submission to the Department.

We will submit all reports to DMS, via electronic channels or other formats, according to Section 37.0 Contractor Reporting Requirements and Department direction. To verify the accuracy and completeness of DMS reporting, our BASIS leadership team performs three-levels of internal quality reviews. These include:

1. *BASIS Team Review*: All initial data extracts are reviewed for accuracy prior to being released for the next level review. The BASIS team report developer and their manager are responsible for this review.

2. *Finance Team Review:* Our Finance and Actuarial team performs an additional review for consistency and accuracy.

3. *Business Partner Review:* Our health plan reporting team will review all Kentucky MCO program reports before submission to confirm completeness and accuracy. This includes a review and attestation performed by the functional lead of the area affected by the report. The team is well versed in the expectations of contractual reporting expected in the execution of state Medicaid contracts.

The BASIS Data Integrity team systematically tests all reporting repositories on a weekly to monthly basis to ensure accuracy and completeness of data. The output of these systematic tests is reviewed against source systems to verify complete record counts until 100% data completeness is achieved.

d. Provide examples of the Contractor's proposed:

i. Processes for conducting comparative data analyses, interpreting trends, and summarizing findings in a manner that is easily interpreted by the Department.

We use comparative data analyses, trends and straightforward dashboard reporting to conduct population health analyses to assess a program's impact on the populations we serve. For our partners in the Commonwealth and ourselves, these analyses confirm that we are allocating

resources efficiently and effectively to programs that can most benefit the population. We monitor program effectiveness by detecting population trends and changes, enabling us to refocus our efforts to meet any new or changing conditions. Our analytic tools support health risk analysis, predictive modeling and care planning activities attuned to diverse populations with complex health care needs. Using these tools, we extract information from clinical and administrative data sources to coordinate and evaluate activities such as:

- Reviewing clinical episodes for continuity of care, assessing current and prior use of prescription drugs for optimum medication treatment
- Mitigating health risks by creating risk markers that are both predictive and clinically insightful to reduce or eliminate hospitalizations and complications
- Using evidence-based guidelines to support care and disease management, medical decision-making and identifying gaps in care

Key examples of reporting and the types of data analysis we perform and report on include:

Identifying Practice Patterns and Applying Those Findings

Using SMART's data analytics capability, we continuously monitor key metrics and trends across various dimensions through monthly performance reviews. If a trend seems to be varying from the norm or expectation, we use standard reports, and root cause analysis processes, to identify the cause of such variations.

For instance, we may conduct a root cause analysis of utilization variations and uncover an increase in the utilization of a specific diagnosis code, procedure code or provider. Uncontrollable factors, such as a flu epidemic, can explain some of these variations, whereas others can lead to actionable items like provider and enrollee outreach/coaching about the use of the ED versus a doctor's office. We review facilities, physicians (PCPs versus specialists), ancillaries (e.g., durable medical equipment, lab and surgical), and pharmacies; drill into significant types of services as appropriate (e.g., inpatient medical/surgical, outpatient-ED, radiology and therapies); analyze important trends by provider within these categories and identify outliers for potential opportunities; and build upon best practices or remediate key providers.

Fraud, Waste and Abuse

As an example of our utilization reporting capabilities, we use a variety of state-of-the-art data analytic tools to identify both enrollee and provider fraud and abuse through UnitedHealthcare and Commonwealth-specific algorithms in our claims processing. These algorithms facilitate review of selected claims before payment to identify aberrant patterns of enrollee utilization post-payment. Data analyses are especially effective in identifying enrollees who:

- Share ID cards to illegally obtain services or prescription drugs for multiple individuals or identification theft
- Shop doctors to get duplicative services or excessive quantities of prescription drugs from multiple providers
- Use emergency facilities inappropriately
- Receive services not supported by provider-reported diagnoses

We also monitor aberrant claim patterns to identify provider fraud and abuse such as unnecessary medical testing, overutilization of office visits and inappropriate coding based upon record reviews.

Please refer to Attachment C.27.a.i. for our sample reporting templates and reports.

ii. Use of dashboard reporting to monitor, track, and evaluate performance metrics, including dashboard level data the Contractor proposes to submit to the Department. Provide a sample dashboard report.

Following are some examples of our dashboards and scorecards used by leadership and the Quality Improvement Committee. The areas of focus include:

- Clinical care
- Service operations
- Enrollee and provider satisfaction
- Patient Safety
- Compliance
- Practitioner credentialing

INNOVATE

In addition to standard reports, SMART users can use predesigned templates and drill down features to analyze high-level trends that pinpoint potential root causes. This helps our management understand business performance and develop effective action plans that address changing business needs. Using the SMART analytics tool, our BASIS team has produced several standard scorecards and dashboards, such as:

- ***Healthy First Steps Scorecard:*** This scorecard focuses on all aspects of maternity-related care, including maternity and case management delivery outcomes, the antepartum average length of stay, admits and days per 1,000, NICU admits and days per 1,000 and case management volumes by care level. Data is based upon authorizations from ICUE, case management data from *CommunityCare* and claims utilization data from the SMART data warehouse. The data warehouse receives claims data from the claims processing system biweekly. The scorecard is refreshed monthly and presented in a Microsoft Excel format. The views can be modified to display national summary or local level metrics. Metrics are organized as year-over-year trending or point-in-time volume metrics.
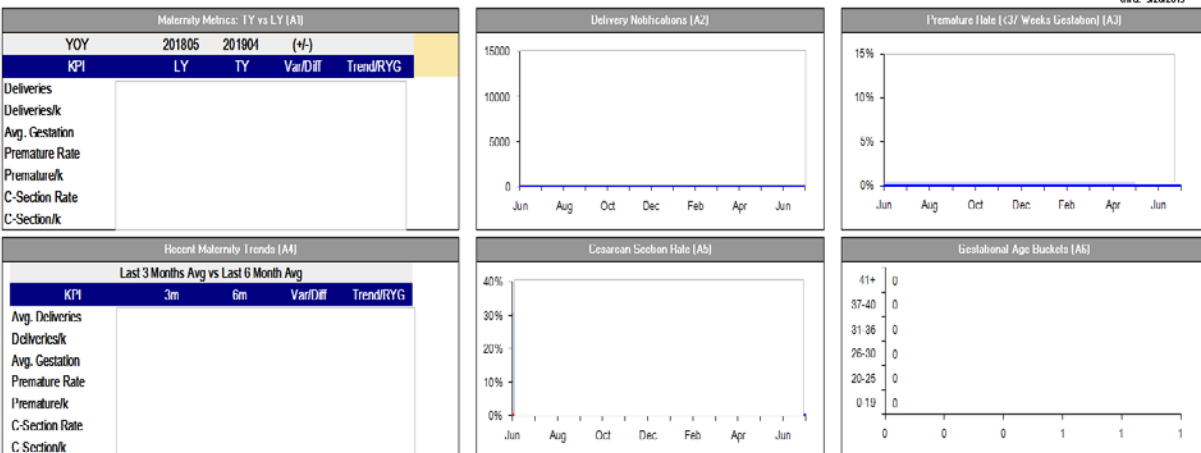

Figure 3. Health First Steps Scorecard focuses on all aspects of maternity related care, including maternity and case management delivery outcomes.

The Health Plan Console: We continuously work to improve integrated care models. As a part of this effort, we have created an innovation focused on a "just in time," centralized system to better access data within our health plans. The Health Plan Console (HP Console) was developed and implemented to verify that leadership has tools readily available to outline key management indicators/metrics for both enrollees and providers. The HP Console can be used to facilitate information sharing among health plan members and their teams (with a minimum necessary need to review) for the purposes of integrated care and management of both provider and enrollee outcomes. For example, the console provides detailed claims information by provider NPI and TIN and retains this information for review of volume of claims processed, denied claims, prior authorization requests and approval rates. For enrollee information, it can track concerns provided through the call center along with claims information. The tool is dynamic and will continue to have modules added as requests for additional comparative information are made.
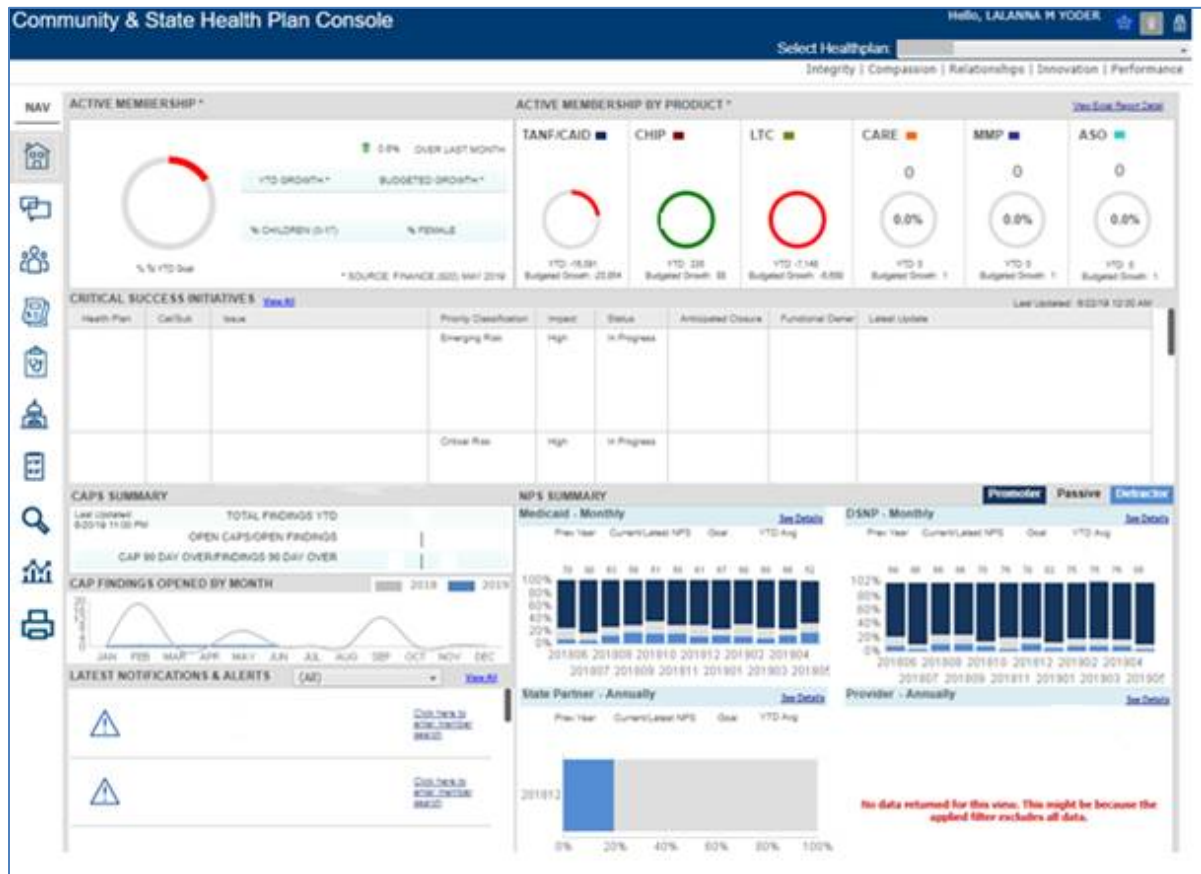

Figure 4. The Health Plan Console outlines key management indicators and metrics for both enrollees and providers. It provides a daily snapshot of key action items for health plan leadership.

We have provided additional sample dashboard reports in Attachment C.27.d.ii.

iii. Use of findings from reports to make program improvements and to identify corrective action.

To improve health outcomes for Kentuckians, we deploy our continuous quality assessment and improvement (QAPI) strategy. At the core of our QAPI is the analysis of data to monitor and improve the quality of care and service delivered across a wide range of clinical and health service-delivery areas, including subcontractors, health services, operations, network management, credentialing, compliance, appeals and grievances, member services and claims.

Reporting to our state partners is a key component Community & State compliance activity, built into the QAPI. For example:

- ***Healthcare Quality & Utilization Management Committee (HQUM):*** Reporting to the ultimate decision-making body, the Quality Improvement Committee (QIC), the HQUM monitors clinical quality improvement (QI) and UM activities and advise on improvement actions. The HQUM reporting review would include analysis of pharmacy trends including fill rates for key medications, denials and prescribing patterns to determine areas for education and/or corrective actions. We also look at utilization and areas like readmission data to determine where we may have opportunities to work with specific hospitals and physicians on patient discharge-plan compliance and effectiveness.
- ***Service Quality Improvement Subcommittee (SQIS):*** The SQIS monitors the quality of service delivered to our membership and reports to the QIC. While care coordinators are the primary identifiers of quality of care and service concerns, any department, enrollee or practitioner, can also identify concerns and report them through "any open door." They collect, review and trend data related to quality of care, quality of service, enrollee experience and administrative issues to identify opportunities for improvement. The SQIS would review call center service levels including speed to answer, abandonment rates and member call-experience data to identify service improvement opportunities. We also look at top reasons for phone calls across all enrollees to help identify educational opportunities and any changes in trends that may be tied to service level gaps and opportunities.

Using our QAPI structure as our foundation for continuous quality improvement, the following case study is an example of a recent operational improvement identified through our quality review process for claims reporting and monitoring.

Case Study: Hospital Bill Auditing

Over time, we realized the need for a more effective way to audit hospital bills. Prior monitoring was disparate and inconsistent. We changed the process to reduce manual monitoring and creating a more automated method.

We now conduct hospital bill auditing prospectively and retrospectively to prevent or recover overpayments and take action against claims where documentation does not substantiate the facility's claim amount against the services rendered. We achieved this by reviewing medical records from specific providers, specific types of services, specific pricing methodologies or other targeted opportunities to make sure services billed were administered. Because of these actions, we have:

- Reduced overpayments
- Increased provider education when and where needed
- Realized a greater opportunity to confirm that services billed were administered

e. Describe the Contractor's processes for monitoring, tracking, and validating data from Subcontractors.

It is incumbent upon UnitedHealthcare and our subcontractors to align our systems and processes to verify the accuracy and consistency of data. As a result, we run a comprehensive data quality program to maintain and monitor data completeness and quality in our SMART data warehouse, which is the primary source of all contractually required reporting. Our process controls validate control totals after each data load from all our sources. Monthly, we run and review our data integrity summary report, which includes several different metrics ensuring the accuracy and completeness of the data. These reports compare the current month's totals to the previous 12 months using Six Sigma standard threshold controls. We have a systemic data

integrity process for claims, encounters and other data received from subcontractors. SMART gathers and stores clinical and claims data, quality measures, prior authorizations, and data from providers or subcontractors to load into SMART and our National Encounter Management Information System (NEMIS).

Our process for monitoring, tracking and validating subcontractor data integrity resides with the BASIS team. The BASIS team validates data after each vendor load in SMART, and monthly, we run and review our Data Integrity Report, which includes several different metrics confirming the accuracy and completeness of the data. These reports compare the current month's totals to the previous 12 months using Six Sigma standard threshold controls. If a subcontractor has a current month volume that is three or more standard deviations from the mean, the metric fails. For any failed metric, the data integrity team researches the issue to determine the root cause and works with the appropriate teams or subcontractor for resolution.

f. Describe the Contractor's proposed process for the receipt, generation, interpretation, and provision of ad hoc reports requested by the Department.

We are fully prepared to submit reports that support the Commonwealth and its initiatives to improve the health of our Kentucky enrollees. We have a designated team of compliance professionals that comprise the Regulatory Account Management Team (RAM). The RAM team is charged with comprehensive management of reporting—including the *receipt, generation, interpretation, and provision of ad hoc and regulatory reports* requested by DMS. In 2019, the Community & State *RAM Team had a 99% on time submission rate for 16,673 standing contract deliverables. Our 12,728 ad hoc requests had a 95% on time submission rate.*

The RAM team is a designated group of compliance professionals within Community & State Compliance who support the compliance officer to build relationships with state regulators and health plan partners by ensuring state regulator requests and contractually required reporting are provided to state partners in a timely and responsive manner. The RAM team has four components: a **Rapid Response Team** (daily management of regulator requests); **Tracking and Oversight Team** (management of daily reports); **Reporting and Special Coverage Team** (provides training and responds to data requests related to deliverables) **Contract Deliverables Team** (oversees receipt and submission of standing contract deliverables).
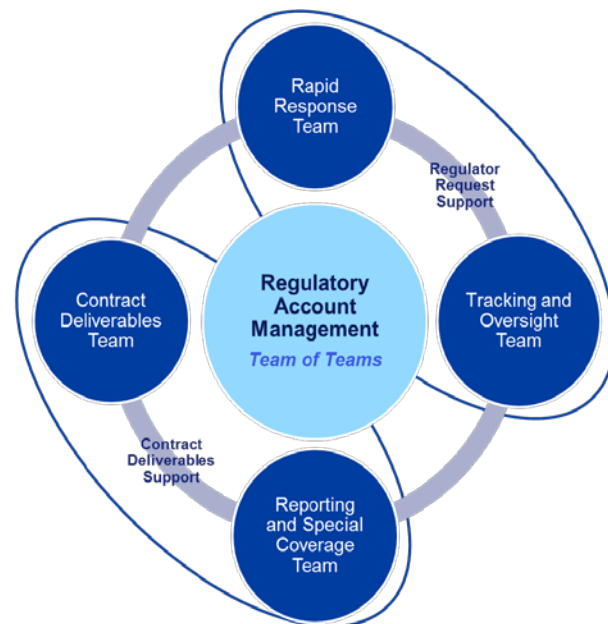

Figure 5. The RAM team provides our state partners with a focused, consistent, customer-driven approach to process management.

The primary mission of the RAM team focuses on:

- Managing to timely and accurate responses to regulator requests and standing contract deliverables.
- Supporting proactive strategic advocacy efforts on emerging trends.

- Driving enhanced categorization of regulator requests for identifying trends and actionable resolutions in Community & State.
- Providing actionable insights and escalation through monthly reporting of trends in elevated volumes and missed state due dates.
- Collaborating with prevent, detect and correct (PDC) to track and trend regulator requests to identify emerging issues across all markets.
- Executing deliverables during peak season and providing support across markets.
- Providing consistent compliance program support in partnership with the health plan compliance officer.
- Conducting deliverable submission training for compliance officers, health planaccountable owners and subject matter experts

We look forward to the opportunity to provide the strength of our reporting and data capability to support the delivery of health care in the Commonwealth to help enrollees have a higher level of engagement and to assist with greater collaboration with providers and community organizations to help the people of the Commonwealth live healthier lives.