ATTACHMENT H
Amended 12/09/2011
Reports

This is a preliminary list of the reporting requirements described throughout the CONTRACT and other ATTACHMENTS. The CONTRACTOR shall include a narrative summary to reports/submissions and may include graphs that explain and highlight key trends. The CONTRACTOR shall comply with all the reporting requirements established by the State. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the liquidated damages described in ATTACHMENT G.

For all the reports listed below, unless otherwise specified, if the CONTRACTOR meets the target for a given report, the CONTRACTOR shall only complete a short narrative description on the report cover sheet. For any report that indicates that the CONTRACTOR is not meeting the target, the CONTRACTOR shall submit a detailed narrative that includes the results, an explanation as to why the CONTRACTOR did not meet the target, and the steps the CONTRACTOR is taking to improve performance going forward.

All reports, unless otherwise specified by the State, shall be stratified. Stratification includes:

- Population groups;
- Service type; or
- Other stratification as requested by the State.

The CONTRACTOR shall submit all reports electronically in the form and format required by the State and shall participate with the State in the development of detailed specifications for these reports. These specifications shall include benchmarks and targets for all reports, as appropriate. Targets shall be changed to reflect improvement in standards over time. The CONTRACTOR shall participate with the State prior to January 1, 2013 in the development of the report formats to be produced by the CONTRACTOR.

The State may, at its discretion, change the content, format or frequency of reports during the term of the contract. The State shall notify the CONTRACTOR of any updates to the report content, formats or frequency and the CONTRACTOR shall comply with all changes specified by the State.

The CONTRACTOR shall transmit to and receive from the State all transactions and code sets in the appropriate standard formats as specified under Federal and State regulations and as directed by the State, so long as the State direction does not conflict with the law.

The following table is a summary of the periodic reporting requirements for the CONTRACTOR and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit the CONTRACTOR's responsibilities in any manner. The deliverables listed below are due by 5:00 PM on the due date indicated, if the due date falls on a weekend or a State Holiday the due date is 5:00 PM on the next business day.

Name of report	Reporting frequency	Report description	Report Due to State
Encounter Data	Weekly	The CONTRACTOR shall prepare and submit encounter data as prescribed in Attachment K to the State through the State's designated Fiscal Agent. Each CONTRACTOR is required to have a valid MMIS Provider Identification Number including a unique identifier. Submissions shall be comprised of encounter records or adjustments to previously submitted records, which the CONTRACTOR has received and processed from provider encounter or claim records of all contracted services rendered to the Member in the current or any preceding months. Submissions must be received by the Fiscal Agent in accordance with Attachment K. CONTRACTOR(S) will submit attestation concurrently with each encounter data submission which states all of the data submitted are, to the best of the CONTRACTOR'S information, knowledge and belief, accurate and complete	As specified by the State
EPSDT Report	Monthly	EPSDT services and reporting shall comply with 42 CFR 411 Subpart B	As specified by the State
Fraud and Abuse Report	Quarterly	The number of complaints of fraud and abuse made to KDHE/DHCF that warrant preliminary investigation, and, for each complaint which warrants investigation, the following information: name-ID number; source of complaint; type of provider; nature of complaint; approximate dollars involved; legal and administrative disposition of the case	As specified by the State
Grievance and Appeal Reports	Quarterly	Report shall summarize formal grievance, appeals, administrative law hearing requests and informal inquiries and resolutions. The report shall summarize formal grievances and appeals and informal inquiries and resolutions (customer service report).	
Health Risk Assessments Report	Quarterly	The number of health risk assessments completed, as well as a summary and analysis of the information collected as it pertains to the prevalence of chronic conditions, need for preventive care, referrals to prenatal care (including the month a pregnant member was identified and screened), and relevant demographic and regional information.	As specified by the State
Hysterectomies and Sterilizations Report		Hysterectomies and sterilizations shall comply with 42 CFR 441 Subpart F. This includes completion of the consent forms.	As specified by the State

Name of report	Reporting frequency	Report description	Report Due to State
Pharmacy Report	Quarterly/On Request	Report to include a list of the providers and information on the interventions the CONTRACTOR has taken with the providers how appear to be operating outside industry or peer norms, have been identified as non-compliant as it relates to adherence to the PDL and/or generic prescribing patters and/or failing to follow required prior authorization processes and procedures. The steps the CONTRACTOR has taken to personally contact each one as well as the outcome of these personal contacts.	As specified by the State
QAPI Report	Annually	As outlined in Attachment J.	As specified by the State
Member Services and Provider Services Phone Line Report	Monthly	Monitoring of member services, provider services, nurse/triage nurse advice and utilization management lines. Data in the report shall be recorded weekly and shall include the detailed rate calculations.	15 days after month end
Utilization Management Report	Annually	Analysis of data and identification of opportunities of improvement and follow up of the effectiveness of the intervention. Utilization data is to be reported based on claim data. Include specific data in Section 2.2.40	As specified by the State
Financial Statements	Quarterly & Annually	As outlined in Section 2.2.28.5.9	As specified by the State
Claims processing/payment Reports	Quarterly	Report to the State enumerating the total number of claims processed during the preceding quarter; percentages of claims paid within 30 days, 60 days and 90 days; and average number of days to pay claims.	As specified by the State
Continuity of Business Operations Plan	Annually	Disaster Recovery Plan	As specified by the State
Access to Care Report		Report pursuant to Section 2.2.15 General Access Standards.	As specified by the State
Licenses Verification	Annually	Provide to the State and EQRO information for verification of Licenses for CONTRACTORS & subcontractors.	As specified by the State
Member Assignment Reports	Monthly	Member assignment to PCP at least one(1) time per month or as assigned by the State and the fiscal agent.	As specified by the State.
Provider network reports	Quarterly	Updated provider network report will include information on all providers of health services, including physical, behavioral health and long-term care providers as outlined in section 2.2.8	As specified by the State.
Institutional Discharges Report	Monthly	Member institutional discharges by category: Inpatient Psychiatric, State Hospital, State Hospital Alternative, PRTFs, nursing facilities, inpatient hospitals	15 days after month end

Name of report	Reporting frequency	Report description	Report Due to State
Customer service report Call Volume Call Timeliness Call Abandonment	Monthly	Measure ACD for all incoming calls The Customer Service call stats report will provide information on total calls received, calls abandoned within 30 seconds, % abandoned, average talk time, average speed of answer, and % answered within 30 seconds by month summarized quarterly and annually. Should also contain the original contact resulting in a formal grievance or appeal with a resolution of 'sent to grievances and appeals process."	15 days after month end
Service authorizations, service denials, and pending service authorizations	Monthly	Number of authorization requests, hours approved and denied, reasons for denial, approved units, paid units, % paid to approved units. This report shall be stratified by program and population as specified by the State.	15 days after month end
Utilization of Services by Service Type and Average Service Utilization	Monthly	Unduplicated count of members receiving any service, total number of all service units paid, grand total amount paid, average number of hours per member, and average amount paid per member. Separate reports for programs as requested by the State.	15 days after month end
Claims Reports	Monthly	Number of open, pended, processed and denied claims in the following categories: 30 days and under, 31-60 days, 61-90 days, over 90 days	15 days after month end
Claims Paid by Provider Type Report	Monthly	Total dollars paid and % of total paid to each of the following provider types: Community Mental Health Centers, Child Welfare Contractors, and Private Providers	15 days after month end
Claims Denial Detail Report	Monthly	The top claims denial reasons. Report will show the highest percentages for each denial reason. Report accompanies Claims Payment Timeliness and Accuracy reports and is contingent on whether claims are high (15% & above).	As specified by the State
Standard Services Preauthorization Decisions Report	Monthly	Total number of standard pre-authorizations: 0-5 days, 6-14 days, > 14 days, and total number of expedited pre-authorizations: 1 day, 2-3 days	15 days after month end
Provider Network Report	Monthly	Net additions/subtractions to the existing provider network based on the following categories: Community Mental Health Centers, Child Welfare Contractors, and Private Providers	15 days after month end
Incidents, Accidents, and Deaths Summary and Trending Report	Monthly	Total incidents, accidents, and deaths received by category, % of total by category accompanied by pie chart representation of data	15 days after month end

Name of report	Reporting frequency	Report description	Report Due to State
Third-party Liability (TPL) Review/Exception Summary Report	Monthly	Total TPL claim lines processed, paid, and denied, include a summary of cost avoidance	15 days after month end
Third Party Liability Report	Quarterly	By category: Medicare, Health Insurance, Spenddown – Claimed and approved amounts, Primary insurer allowable amount, primary insurer paid amount, paid amount, COB savings	30 days after quarter end
Income and Expense Statement (Unaudited)	Quarterly	Revenue, Administrative Services Revenue, Expenses, Net Income (Loss)	30 days after quarter end
Statement of Financial Position	Quarterly	Assets -- Total Cash, Total Reimbursement Funds, Total Investments, Total Other Assets, Total Current Assets, Net Fixed Assets, Liabilities and Equity -- Total Current Liabilities, Total Liabilities, Total Equity	30 days after quarter end
Incurred but Not Reported (INBR) Claims Report	Quarterly	Liability Type (Amount), Administrative Costs Incurred but Not Reported (Amount)	30 days after quarter end
Clean Claims Payment Timeliness and Accuracy Report	Quarterly	# of Lines and % of Total for claims paid and denied by the following categories: 0-30 days, 31-60 days, 61-90 days, >90 days	30 days after quarter end
Group 2 Paid Claims Report	Monthly	A monthly report of Group 2 paid claims. SRS is obligated to reimburse the CONTRACTOR for the payments made for Group 2 beneficiaries. This report is needed to ensure correct federal reporting for these claims. Data certification must be submitted concurrently.	As specified by the State
Provider Credentialing Report	Quarterly	Individual Providers: complete applications processed in 30 days and more than 30 days; CMHCs: complete applications processed in 30, 90, and more than 90 days	30 days after quarter end
Credentialing Review	Annually	Review of credentialing files by audit done at on-site visits. SRS Licensing reports included in CONTRACTOR's credentialing files	As specified by the State
Network Adequacy Assurance	Quarterly	Total # members, Total members in range, total members outside range, % in range, by geographic designation: Urban/semi-urban, densely settled, and rural/frontier.	30 days after quarter end
Call Center Access and Responsiveness Report	Quarterly	By member and by provider: average speed of answer, call abandonment percentage, # busy signals, hold time in seconds	30 days after quarter end

Name of report	Reporting frequency	Report description	Report Due to State
Overview of Corporate Compliance Department Activity	Quarterly	Cumulative data regarding routine Medicaid Claim Verification Audits, overpayment reasons pre and post appeal. Separate reports for programs as specified by the State.	30 days after quarter end
Member Outreach and Educational Offerings Report	Quarterly and Annually	Description of activity and number of attendees at outreach activities and educational offerings for members. Quarterly cumulative reports by fiscal year showing outreach activities such as meetings, presentations, coalition involvement, recovery focused events and tip sheets. Outreach will also be shown for priority populations. A new plan for the coming fiscal year will be included with the combined quarterly/annual report due in January. Also: Review of reports at annual onsite visit	30 days after quarter end and 30 days after fiscal year end
New Member Mailings Report	Quarterly	Total New Member Names Received, information distributed 0-15 days, information distributed 16+ days, total number of member distributions	30 days after quarter end
Critical Incident Report	Quarterly	Type of incident, and number of incidents reported by providers	30 days after quarter end
Grievance Summary and Trends Report	Quarterly	Type of grievance and number of grievances per catchment area.	30 days after quarter end
Out-of-state Placement and Treatment Summary	Quarterly	State, name of facility, type of facility (inpatient psych, PRTF, or inpatient hospital), age ranges 0-4, 5-12, 13-17, and 18+	30 days after quarter end
CAHPS/HEDIS Report	Annually	Submit an annual report of audited CAHPS results and audited HEDIS results.	30 days after fiscal year end
Continuity of Business Operations Plan	Annually	Disaster Recovery Plan	30 days after fiscal year end
Provider Manual Updates	Annually	Summary of Provider Manual Updates/new Provider Manual	30 days after fiscal year end
Member Handbook Updates	Annually	Summary of Member Handbook Updates/new Member Handbook	30 days after fiscal year end
Provider Satisfaction Survey	Annually	Copy of latest Provider Satisfaction Survey	30 days after fiscal year end
Provider Network Development Plan and Education	Annually	Summary of efforts to develop and educate the existing provider network as well as analysis of trends and plans for further provider network development and education for the upcoming fiscal year.	30 days after fiscal year end

Name of report	Reporting frequency	Report description	Report Due to State
Provider Report Card /NOMS	Annually	Provider Performance Indicators designed to monitor data that ensures quality services with positive clinical outcomes. NOMS Outcome Reporting including: SAMHSA National Outcome Measures NOMS (Abstinence, Employment/Education, Crime and criminal Justice Involvement, Stability in Housing, Social Connectedness) Access/Capacity, Retention, Perception of care, Cost-Effectiveness and Use of Evidenced-based Practices etc.	30 days after fiscal year end
Geographic Mapping Reports	Annually	Geographic mapping reports detailing single and multiple provider locations by the following categories: Urban/suburban, Densely settled, Rural/Frontier.	30 days after fiscal year end
Quality Assessment and Performance Improvement Work Plan	Annually	Detailed summary of annual quality assessment/performance improvement efforts and results of those efforts.	30 days after fiscal year end
Member Satisfaction Survey	Annually	Copy of latest Member Satisfaction Survey	30 days after fiscal year end
Parties of Interest Transactions Statement	Annually	Summary detailing transactions with parties of interest relating to the furnishing of services in the administration of the contract.	30 days after fiscal year end
Claims Data by FQHC and RHC In and Out of Network Providers	Annually	The FQHC and RHC Claims report provides a combined annual payment history displayed by month for all network and non-network FQHCs and RHCs providing services to Medicaid clients. The details of the report include the provider number, provider name, service rendered, check number, check paid data, and total amount paid.	Monthly when activity occurs
Final Independently Audited Financial Statements	Annually	Report of the Auditors of the Contractor This is an annual independent audit of the CONTRACTOR's statutory statements of admitted assets, liabilities, capital and surplus of the CONTRACTOR and the related statutory statements of revenues and expense, changes in capital and surplus, and cash flows for the calendar year.	As specified by State
Onsite Review	Annually	Annual onsite review of Contractor by State staff and may include oversight of Contractor Personnel staffing, Credentialing, Utilization Management, Quality Improvement, Care Coordination with other Systems, Care Coordination with Special Health Care Needs Clients, Care Coordination with Medical Providers, General Info and Member Outreach.	April

Name of report	Reporting frequency	Report description	Report Due to State
Department of Insurance Filings Audit Report	Quarterly & Annually	This is a Department of Insurance report to the State of Kansas Insurance Department and the Medicaid agency	Monitor when submitted
Utilization of Services Report	Quarterly, three months in arrears	By service, unduplicated # members receiving services, mean hours per member, mean service units per member, and mean reimbursement per member. Data is reported by catchment area and statewide and by ages 0-17 and 18+.	As specified by the State
SED Waiver Requested Services and Service Delivery by Dates of Service Report	Quarterly, three months in arrears	# of requested and provided (not necessarily paid) units of service for SED Waiver services. Data is reported by specific SED Waiver service.	As specified by the State
SED Waiver Frequency of Services by Dates of Service Report	Quarterly, three months in arrears	# of registrations, # of SED Waiver members with a service, % of SED Waiver members receiving a service. Data is reported by catchment area and statewide.	As specified by the State
Members Presenting for Screen with Previous Service (30 days prior to screen) Report	Quarterly, three months in arrears	# of screens, # admitted, # diverted, members with screen, % of members receiving a service 30 days prior to screen date	As specified by the State
Alternative Community Plan (Diversion) Follow-up Services Report	Quarterly, three months in arrears	# requiring follow-up services, % receiving services within 72 hours of development of alternative community plan (diversion)	As specified by the State
SED Waiver Member Outcome Indicators Report	Quarterly	Outcome indicators include: Permanent Family Home, Regular School Attendance, Without Law Enforcement Contact, A, B or C grades in School, Significant CBCL scores for children/youth receiving SED Waiver services. Data is reported by CMHC and statewide	As specified by the State
SED Waiver Psychiatric Screens Report	Quarterly	Psychiatric Screens: Admissions and Diversions for children/youth receiving SED Waiver services. Data is reported by CMHC and statewide.	As specified by the State
SED Waiver Grievance Summary and Trends	Quarterly	Grievances reported involving children/youth receiving SED Waiver services. Data is reported by CMHC and statewide	As specified by the State
SPMI and SED Member Outcome Indicators Report	Quarterly	Outcome indicators include Permanent Family Home, Regular School Attendance, Without Law Enforcement Contact, A, B or C grades in School, Significant CBCL scores, Post-Secondary Education (SPMI).	As specified by the State

Name of report	Reporting frequency	Report description	Report Due to State
Percentage of CBST Reviews Completed within Established Timeframe Report	Quarterly	# of CBST meetings, # and % completed in fewer than 7 days, # and % completed in greater than 7 days. Separate tables for initial, extension, and exception meetings. Standard: 95% of CBST meetings are completed in fewer than 7 days.	As specified by the State
Alternative Community Plans (Diversions) from Inpatient Care Report	Quarterly	Separate reports for Inpatient psychiatric and PRTF facility types. Total assessments, total admissions and diversions, and % of assessments leading to a diversion. Data is reported by catchment area and statewide.	As specified by the State
Discharge to Homelessness Report	Quarterly	By month, # of inpatient discharges, # and %, (less than 3% for Adults, 1.5% for children) of discharges to homelessness. One table for children/youth 0-17 and one for adults. Each discharge to homelessness should be accompanied by an explanation as to why it occurred.	As specified by the State
Inpatient Discharges to Community Report	Quarterly	# and % discharged to home/family/friend, foster home, nursing home, and group home. Discharges are tracked from the following facility types: PRTF, state hospitals, inpatient psychiatric facilities, and state hospital alternatives. Discharges are not exclusive to mental health contract. Data is reported by catchment area and statewide.	As specified by the State
Evidence-Based Practice Fidelity Report (for sites with evidence-based practice programs)	Quarterly	Most recent fidelity review date, date program met fidelity for enhanced rate; date decertified and recertified, and date next fidelity review due by CMHC.	As specified by the State
All Members Penetration Rate Report	Annually	Total members served, % to Total Medicaid population, Penetration rate per 1,000 KHS members and per 10,000 Kansas population. Data is reported by catchment area.	As specified by the State
Member Penetration Rates to Medicaid Population by Diagnostic and Service Categories by Dates of Service Report	Annually	Diagnostic and service categories include: total members, total SED Waiver members, total non-English speaking members, total dual diagnosis (SUD and MH) members, total dual diagnosis (MR/DD and MH) members, Total SPMI members, total outpatient mental health members, total outpatient medication management services members. Data is reported by catchment area and statewide.	As specified by the State
Member Penetration Rates to Kansas Estimated U.S. Population by Diagnostic and Service Categories by Dates of Service Report	Annually	Diagnostic and service categories include: total members, total SED Waiver members, total non-English speaking members, total dual diagnosis (SUD and MH) members, total dual diagnosis (MR/DD and MH) members, Total SPMI members, total outpatient mental health members, total outpatient medication management services members. Data is reported by catchment area and statewide.	As specified by the State

Name of report	Reporting frequency	Report description	Report Due to State
Summary of Quality Management Activities Report	Annually	Youth Focused Study Program Improvement Plan, Adult Focused Study Program Improvement Program	As specified by the State
Network Analysis of Providers by Agency Report	Annually	Net % change in number of licensed mental health practitioners at the end of the fiscal year compared to the same percentage at the end of the prior fiscal year.	As specified by the State
Network Analysis of Certified Providers Report	Annually	# participating in specific service online courses by course name; peer support training, and interactive community event (ICE) training. Separate reports for individual training contractor.	As specified by the State
Medicaid Waiver Report	Quarterly	Quarterly report used by Management Operations to report federal spending to KDHE-DHCF. Report includes the utilization (total units and dollars by month) for all Medicaid members who had Reintegration or Intermediate services (b3 services) paid since the beginning of the contract. Unique members are unduplicated by month. Each new quarter is added to the end of the report. Data is reported by the date in which the service was paid.	As specified by the State
Dashboard report	Monthly	Fiscal and Utilization Dashboard reports of the managed care CONTRACTOR(S) for SRS Management. Utilization report includes trending graphs of higher and lower levels of care admissions, higher levels of care average length of stay, unique members served, Medicaid penetration rates, higher levels of care male and female readmissions and access to care for urgent, routine and IV Drug Users. Fiscal dashboard to be determined.	As specified by the State