**ATTACHMENT H**

**Reports and Data Elements**

The State is implementing a new reporting and data collection strategy that collects, integrates, and analyzes data from a variety of sources, including required CONTRACTOR(S) self-reporting across the full continuum of care.

To ensure that all data types are captured, the State has developed a list of current reports and key data types related to this Request for Proposal (RFP) that will be required for submission to the State for analytics and reporting. The CONTRACTOR(S) must be able to attest to the accuracy, completeness and truthfulness of the documents and data as required in section 5.14.3.A.

CONTRACTOR(S) shall certify data including, but not limited to, all documents specified by the State, enrollment information, encounter data, and other information contained in contracts, proposals. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The CONTRACTOR(S) must submit the certification concurrently with the certified data and document. Data must be certified by one of the following:

1. The CONTRACTOR(S) Chief Executive Officer
2. The CONTRACTOR(S) Chief Financial Officer
3. An individual who has delegated authority to sign for, and who reports directly to, the CONTRACTOR(S)’ Chief Executive Officer or Chief Financial Officer.

The CONTRACTOR(S) shall review the report list provided below and determine if the report or data type is currently available for submission. For all LTSS and Behavioral Health services related reporting, CONTRACTOR(S) shall provide detailed line item data elements utilized   in the development of the aggregate reports. The CONTRACTOR(S) must also speak to the ability to submit the data at the frequency required by the State. Please complete columns 4–7 (headings are shaded in grey) with as much detail as possible.

**Yes** The CONTRACTOR(S) can fully support this requirement.

**Partially** The CONTRACTOR(S) can partially support this requirement. Provide detail on what is and is not supported, (use Data Details column) intent to modify systems, and timeframes associated with modifications needed to support requirement in its entirety.

**Future** The functionality is planned as a future enhancement. Provide the scheduled date for availability in the Details column.

**No**  The CONTRACTOR(S) solution does not support this requirement.

**Data Details** The CONTRACTOR(S) may provide details of their reporting and data capabilities for each report item using this column.

For each data type and report, the CONTRACTOR(S) must provide details as to how the data is captured and submitted (file formats, etc.), as well as which system(s) house the data and the existence of any data dictionaries associated with the data elements. The CONTRACTOR(S) shall provide an example of each report type. (Please note it is not necessary to send reports in their entirety. A sample that demonstrates the CONTRACTOR(S)’s capability in each area is sufficient).

The CONTRACTOR(S) may include a narrative summary that further illustrates development activities describing how the key data elements will be reported and/or provided if there is not a current report or file that is currently available for submission.

| **Report Name** | **Reporting Description** | **Frequency** | **Report Available****Y/N/P** | **Data Available****Y/N/P** | **Data Dictionary****Y/N** | **Data Details - key elements, system description, submission format, etc.** |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Grievance and Appeal Reports(GAR)/ Appeals Resolution Timeframe
 | Report summarizing formal grievance and appeals including those related to physical and behavioral health, long term services and supports (LTSS), and pharmacy services, administrative law hearing requests and informal inquiries and resolutions. The report must also incorporate any grievance and appeals data related to determinations performed by a contracted entity on behalf of the CONTRACTOR(S). The GAR report must contain Member grievance, appeal and State Fair Hearing data, as well as Provider Reconsideration, Appeal and State Fair Hearing data. The report lists complaints from escalation to grievance. Types of appeals include:* Standard appeals: Numerator: Number of appeals resolved within 14 to 30 days. Denominator: Total number of standard appeals.
* Expedited appeals: Numerator: Number of expedited appeals resolved within 3 business days. Denominator: Total number of expedited appeals received.
 | Quarterly |  |  |  |  |
| 1. Grievances - Transportation
 | Monthly report of grievances pertaining to transportation issues including no shows, late, and safety issues. | Monthly |  |  |  |  |
| 1. Preferred Drug List Report
 | List of prescription drugs, both generic and brand name that are preferred by the CONTRACTOR(S). | Monthly |  |  |  |  |
| 1. Prior Authorization Pharmacy Summary
 | Summary report of pre-authorizations. Metrics include: * Total standard pre-authorizations:
	+ 0–5 days
	+ 6–14 days
* Total expedited pre-authorizations:
	+ 1 day
	+ 2–3 days
 | Monthly |  |  |  |  |
| 1. Step Therapy Savings Report
 | Utilization savings per month for Step Therapy. | Monthly |  |  |  |  |
| 1. Title 21 Vaccine report
 | Summary of number of vaccines paid for Title XXI children; stratified by age range and vaccine type. | Quarterly |  |  |  |  |
| 1. Medication Therapy Management Monthly Report
 | Summary of medication therapy management cases completed, including the number of comprehensive medication reviews, generated and completed number of targeted medication reviews, generated and completed number of patient and pharmacist declined cases, and number of participating pharmacies. | Bi-Annually |  |  |  |  |
| 1. Prescription Prior Authorization Override Report
 | Report of prior authorization overrides with the following parameters: * 3-day
* 5-day
* 60-day
* Override codes
 | Monthly |  |  |  |  |
| 1. Provider Participation - Adverse Actions Taken Against Providers
 | Report of any adverse action taken against a provider’s participation in the program, including credentialing denials for fraud-related concerns. | Monthly |  |  |  |  |
| 1. Overview of Corporate Compliance Department Activity
 | Activity report of Corporate Compliance Department to include: Name of compliance officer, meeting topics, staff training and education overview, communications to staff, disciplinary measures, and corrective actions. | Quarterly |  |  |  |  |
| 1. Payment Integrity Report
 | Report of cost avoidance efforts through front-end edits and dollar amounts identified and recovered through Fraud, Waste and Abuse detection efforts. | Quarterly |  |  |  |  |
| 1. Disclosure of Ownership
 | Quarterly review of random sample of revalidated and newly contracted Participating Providers. | Quarterly |  |  |  |  |
| 1. Program Integrity Risk Assessment
 | CONTRACTOR(S) and SUBCONTRACTOR(S) assessments of Fraud, Waste, Abuse and Payment Integrity procedures. List top five vulnerable areas and corresponding mitigation plans.  | Annually |  |  |  |  |
| 1. Fraud and Abuse Report-MEMBER and PROVIDER
 | Status report of fraud and abuse investigations. Report to include both Member and provider summary statistics and lock in statistics. | Quarterly |  |  |  |  |
| 1. Provider Participation - Adverse Actions Taken Against Providers
 | Summary of adverse actions of provider participation. Report to include corrective action plans and timelines as well as an indication of reports to the Department of Health and Human Services’ Office of the Inspector General (HHS-OIG). | Monthly |  |  |  |  |
| 1. Verification of Services Provided
 | Reimbursed services performed by Participating Providers verification report.  | Monthly |  |  |  |  |
| 1. Customer Service Report, Member Services and Provider Services Phone Line Report, Telephone and Internet Activity Report Call Center Access and Responsiveness Report
 | Reports from CONTRACTOR(S)/Subcontractor(s)) is to monitor Member and provider services, nurse/triage nurse advice and utilization management lines to include but not limited to:* Total calls received
* Calls abandoned within 30 seconds
* Percent abandoned
* Average talk time
* Average speed of answer
* Percent answered within thirty (30) seconds

Reports to monitor:* Call volume
* E-mail volume
* Average call length
* Average hold time
* Blocked call rate
* Original contact resulting in grievance
 | MonthlyQuarterly and Annually |  |  |  |  |
| 1. IDD Residential Policy
 | Update of MCO’s implementation of State IDD Residential Pay Policy. | Monthly |  |  |  |  |
| 1. IDD Program Report
 | Implementation report of status for network development, claims processing, issues, grievance and appeals, Member management, person centered service plan (PCSP) turnaround times, provider outreach and critical incidents. | Monthly |  |  |  |  |
| 1. Home and Community Based Services (HCBS) PCSP Report
 | Report of any fluctuation in plans of care by HCBS, HCBS-TC and WORK programs for Members and units. | Quarterly |  |  |  |  |
| 1. Extraordinary Funding
 | Report of status of persons reimbursed with extraordinary funding, authorizations for extraordinary funding, review date, approvals and denials with explanation and dates of communication to the community service provider of the status of extraordinary funding. | Quarterly |  |  |  |  |
| 1. KanCare LTSS Oversight Report
 | Hiring status report of service coordination positions, service coordination turnover rate, caseloads, LTSS enrollment, and service coordination contacts for Members, annual reviews and Money Follows the Person (MFP) referrals. | Monthly |  |  |  |  |
| 1. RADAC Referral Reporting
 | Report that includes names of Members referred, date of referral, date of initial contact, first date of service, CONTRACTOR(S) service coordinator name, last service coordinator contact, service coordination hours provided, Medicaid services being provided including primary, secondary and others, examples of referrals made, housing status, employment status, SUD treatment, connection to behavioral health services and any barriers in contact or service provision.  | Monthly |  |  |  |  |
| 1. Screening, Brief Intervention and Referral to Treatment (SBIRT) Summary Billing reporting
 | Screening, Brief Intervention and Referral to Treatment (SBIRT) Summary Billing reporting including number of Members screened, number of units billed, total dollar amount claimed, and number of claims received.  | Quarterly |  |  |  |  |
| 1. Value Added Benefits
 | Utilization report of Member population type plan benefits offered beyond the State Plan services. | Monthly |  |  |  |  |
| 1. In Lieu of Report
 | Report of Medicaid allowable services and non-Medicaid services provided to the following populations:* Members on waiting list for C waiver who receive waiver-like services
* Members that need additional waiver or different Medicaid services
* Members eligible for Medicaid that require a non-Medicaid service regardless of waiver status
 | Monthly |  |  |  |  |
| 1. Geographic Mapping Reports (Geo-Access)
 | Geographic mapping report detailing single and multiple provider locations by category, modality(for example, xxx), region and county to include:* Urban/suburban
* Densely settled
* Rural/frontier

Report must include separate maps for adult and pediatric populations and specify that at a minimum report must include the following: physicians, including specialists; vision; dental; hospitals; pharmacies; behavioral health Providers; and LTSS, per 42 CFR 438.68 requirements. In addition, this report must include analysis of any provider gaps and corrective actions for remediation of gaps. | Quarterly |  |  |  |  |
| 1. Network Adequacy (Provider Network Report)
 | The CONTRACTOR(S) must provide reports for Medicaid /CHIP populations. These electronic reports must be in Excel and list all Providers’ names and addresses, including primary care Providers (PCPs), LTSS Providers, and specialists per the State-provided report template. Providers must have an indicator for open/closed panels and include the number of Members assigned to each provider and provider’s maximum caseload. This will be a full file replacement per quarter.  | Quarterly |  |  |  |  |
| 1. Network Adequacy Utilization
 | Report with Providers by National Provider Identifier/Tax Identification Number (NPI/TIN), Total Paid, Total Claims (Header) and Total Members. Include both claim and Member counts by month. Must include separate reporting for adult and pediatric populations and specify that at a minimum report must include the following: physicians, including specialists; vision; dental; hospitals; pharmacies; behavioral health Providers; and LTSS, per 42 CFR 438.68 requirements. | Quarterly |  |  |  |  |
| 1. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Report
 | Analysis report of audited CAHPS results including but not limited to the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey using the most current CAHPS version specified by the National Committee for Quality Assurance (NCQA).Track and trend all aspects of the survey including mitigation plans. | Annually |  |  |  |  |
| 1. HEDIS Annual Reporting
 | Analysis report of audited HEDIS results. Track and trend all aspects of the survey including mitigation plans.The State may also request interim HEDIS reports each quarter to assess MCO performance throughout the year. | Annually and upon State request, quarterly |  |  |  |  |
| 1. Staffing Contingency Plan Updates
 | Staffing contingency plan to include but not limited to the following:* Replacement of personnel before or after signing of contract process
* Allocation process of additional resources in response to inability to meet any performance standard
* Staff replacement process to include time frames
* Replacement/additions onboarding process to include Kansas Contract emphasis
 | Annually |  |  |  |  |
| 1. 5% Ownership Report
 | Written report of any person or corporation that has 5% or more ownership or controlling interest in the entity. Report must include financial statements of identified persons.  | Annually |  |  |  |  |
| 1. Continuity of Business Operations Plan
 | Business continuity report that includes (at minimum):* Recovery of business functions, business units, business processes, human resources, and technology infrastructure
* Core business processes
* Maintenance of updated disaster recovery plans and procedures
* Plan for replacement of personnel

Please note that if approved plan is unchanged from previous year, a certification from the year prior must be submitted. | Annually |  |  |  |  |
| 1. Member Handbook Updates
 | Summary of updates to Member/new Member handbook. Summary to include verification of handbook review. | Annually |  |  |  |  |
| 1. Organizational Charts
 | Organization chart with quarterly changes noted and a focus on key positions and care coordination, including positions that have direct contact with Members. | Quarterly |  |  |  |  |
| 1. Security Plan Updates
 | Summary of any updates to the Security Plan. | Annually |  |  |  |  |
| 1. Insolvency Plan
 | Insolvency plan that includes provisions for dividing the cash reserves, capital and surplus requirement among plan Providers in the event of insolvency. | Annually |  |  |  |  |
| 1. Performance Bond
 | Written assurance stating the required performance bond will be submitted no later than forty-five (45 days) after contract signing. | Annually |  |  |  |  |
| 1. Children and Youth with Special Health Care Needs (CYSHCN)
 | Summary of CYSHCN who receives Medicaid coverage who require a health care plan. Report to include:* Date of birth (DOB)
* Policy (ID)
 | Monthly |  |  |  |  |
| 1. Health Risk Assessments Report
 | Number of completed health risk assessments, as well as a summary and analysis of the information collected as it pertains to chronic conditions, preventive care, prenatal care referrals including the month a pregnant Member was identified and screened, and relevant demographic and regional information.Report to include:* Number of Members screened
* Number of Members refusing screen
* Number of Members unable to contact for screen
* Number of Members referred for an HRA
* Number of Members with an HRA completed
* Number of Members refusing an HRA
* Number of Members with an HRA completed telephonically or in-person
 | Quarterly |  |  |  |  |
| 1. Health Insurance Portability and Accountability Act (HIPAA) Monthly Summary
 | Notification report of all impermissible HIPAA uses and disclosures to include those that do not rise to the level of a HIPAA breach that require formal notification of the individual and HHS. | Monthly |  |  |  |  |
| 1. Hysterectomies and Sterilizations Report
 | Report demonstrating compliance with 42 CFR 441 Subpart F and completion of consent forms. | Quarterly |  |  |  |  |
| 1. Community Transitions
 | Monthly report of participants transitioning from an institutional setting and details of their program participation. Institutional setting will include, but not limited to, Nursing Facility, Nursing Facility for Mental Health, State and Private Intermediate Care Facilities (ICFs), State Hospitals, Psychiatric Residential Treatment Facilities (PRTFs) and other Psychiatric Impatient Settings. | Monthly |  |  |  |  |
| 1. Pay for Performance 2017
 | Report listing the KanCare Pay for Performance reporting measures. | Quarterly |  |  |  |  |
| 1. Serious Emotional Disturbances (SED) Waiver Performance Measures-Quarterly
 | Report of performance measures specific to the SED Waiver. The report shall include:* Grievance resolution timeframe
* Paid claims not resulting in recoupment
* Claims verified to have paid according to the service plan
 | Quarterly |  |  |  |  |
| 1. Standard Terms and Conditions (STCs) Quarterly Report
 | Activity report on marketing, outreach and advocacy for Standard Terms and Conditions. | Quarterly |  |  |  |  |
| 1. Foster Care Reporting
 | Summary of all children in foster care, by population code with CONTRACTOR(S), current address and mental health diagnosis along with an indicator if the child has high needs. | Monthly |  |  |  |  |
| 1. Member Outreach and Educational Offerings Report
 | Summary of Member outreach and educational offerings. Report to include:* Number of attendees
* Types of activities including meetings, presentations, coalition involvement, and recovery focused events and tip sheets
* Demonstration of outreach for priority populations
 | Quarterly |  |  |  |  |
| 1. WORK Allocation Report
 | Detail listing containing one line per participant listing the participant's monthly allocation amount as showing in the patient pay liability (PPL) Web Portal and include Participant PPL ID number; Participant Medicaid number; Participant First Name; Participant Last Name; Month Start Date; Month End Date; Monthly Allocation; Unallocated Amount; Allocated Amount; Total Spent Amount including Total spent on prior authorization (PA) services, Total spent on alternative services, Total reimbursements; Total Swept Amount; Monthly Allocation Balance. | Monthly |  |  |  |  |
| 1. WORK Enrollment End Date Report
 | Detail listing containing one line for each participant in the program and list the enrollment start and end dates (if applicable) that have been entered by the participant's ILC or Case Manager into the PPL Web Portal and include: Participant PPL ID; Participant First Name; Participant Last Name; Enrollment Begin Date; Enrollment End Date. | Monthly |  |  |  |  |
| 1. WORK Good to Go (GTG) Report
 | Detail listing containing one line for each participant/provider association in the Web Portal to include: * Participant Patient Pay Liability (PPL) ID
* Participant First Name
* Participant Last Name
* Participant GTG Status
* Provider PPL ID
* Provider Name
* Provider First Name
* Provider Last Name
* Provider Type
* Provider GTG Status
* Participant Provider Checklist Status Independent Living Counselor (ILC) First Name
* ILC Last Name
* Assessment CONTRACTOR(S) First Name
* Assessment CONTRACTOR(S) Last Name
 | Monthly |  |  |  |  |
| 1. WORK ILC Billing Audit File
 | Audit file of ILC billing submitted during reporting quarter. | Quarterly |  |  |  |  |
| 1. WORK Participant Funds Summary Reports
 | Detail listing containing one line per participant summarizing their monthly allocations for the month(s) the report is run and the participant's carryover and overflow information. The reports are cumulative and include: * Participant PPL ID
* Participant Medicaid Number
* Participant First Name
* Participant Last Name
* Sum of Monthly Allocations
* Total Unallocated
* Total Allocated
* Total Spent (Total spent on prior authorization services, Total spent on alternative services, Total reimbursements)
* Total Swept
* Total Monthly Allocations Balance
* Carryover Budget
* Carryover Unallocated
* Carryover Allocated
* Carryover Spent
* Carryover Balance
* Overflow Budget
* Overflow Unallocated
* Overflow Allocated
 | Quarterly |  |  |  |  |
| 1. Annual CONTRACTOR(S) Evaluation Report
 | Detail of the annual review of the Quality Assessment and Performance Improvement (QAPI) program. The report, at a minimum, to include:* Summary and review of completed and continuing quality improvement activities that address the quality of clinical care and services
* Trending and analysis of performance measures of quality of clinical care and services
* Recommended corrective actions that are implemented or in progress
* Modifications to the QAPI program
 | Annually by end of first quarter following the year being evaluated. |  |  |  |  |
| 1. Performance Improvement Projects
 | Updates for all Performance Improvement Projects (PIPs) that have been approved by the State. Reports must be submitted on the approved State form and include:* Rationale for conducting the PIP and its impact on the KanCare program
* Objective quality indicators to be used in assessing PIP effectiveness
* Baseline assessment and goals/benchmarks for improvement
* Implementation of system interventions to achieve improvement
* Evaluation and barrier analysis of the effectiveness of the interventions
* Planning and initiation of activities for increasing or sustaining improvement

Reporting the results of each project to the State. | Quarterly |  |  |  |  |
| 1. Quality Assessment and Performance Improvement Work Plan
 | Executive summary of annual quality assessments and performance improvement efforts and results. Report to include all changes, providing the substantive nature of each and the impetus of each (e.g., responsive to a review finding, update to an NCQA standard, etc.); and separately provide substantive updates on each area of the QAPI plan. | Semi-annually |  |  |  |  |
| 1. Standard Services Preauthorization Decisions Report
 | Total number of standard pre-authorizations:  0–5 days,6–14 days, more than14 days, and total number of expedited pre-authorizations: 1 day, 2–3 days | Monthly |  |  |  |  |
| 1. Turnaround Time (TAT) Prior Authorization Report [Standard Services Preauthorization Decision Report (Service Authorizations, Service Denials, and Pending Service Authorizations)]
 | Summary of TAT to be stratified by program and population. Report to include:* Number of authorization requests
* Hours approved and denied
* Reasons for denial
* Approved units
* Paid units
* Percent paid to approved units
* Total number of pre-authorizations
 | Quarterly |  |  |  |  |
| 1. Provider Manual Updates
 | Summary report of updates to provider manual. Summary to include verification of manual review.  | Annually |  |  |  |   |
| 1. Utilization of Services by Service Type and Average Service Utilization
 | Utilization report to include:* Members receiving any services
* Total number of all service units paid
* Grand total amount paid
* Average number of hours per Member
* Average amount paid per Member
* Drug utilization to include
	+ Total number of units of each dosage form
	+ Strength and package size by NDC of each covered outpatient drug administered to Members
 | Monthly |  |  |  |  |
| 1. Final Independently Audited Financial Statements
 | The CONTRACTOR(S) shall submit to the State Annual Audited Financial Statements as they become available and no later than June 1st. The CONTRACTOR(S) shall submit to the Kansas Insurance Department the results of an annual audit performed by an independent certified public accountant and to authorize the Kansas Insurance Department (KID) to share this information with other State agencies as required. The CONTRACTOR(S) shall authorize the independent accountant to allow representatives of the State, including the KID, upon written request, to verify the audit report.The CONTRACTOR(S), the CONTRACTOR(S)’ parent company, and all non-provider SUBCONTRACTOR(S) that are not affiliated with the CONTRACTOR(S) will provide the results of an annual audit performed by an independent Certified Public Accountant and to authorize the CONTRACTOR(S) to share this information with the State. The CONTRACTOR(S) shall authorize the independent accountant to allow representatives of the State, upon written request, to verify the audit report. | Annually |  |  |  |  |
| 1. Financial Package -Monthly Edition
 | Generally Accepted Accounting Principles (GAAP) financial report of the KanCare program to be submitted by the CONTRACTOR(S) monthly. Details around the Title XIX and Title XXI programs are required. The State provided financial reporting template includes several tabs for input including a Medical Loss Ratio (MLR) report, restated financial report covering a two-year period and a SUBCONTRACTOR(S) report detailing various components of payments made to SUBCONTRACTOR(S). Also included in the template are quarterly reporting requirements such as reconciliation between National Association of Insurance Commissioners (NAIC) and GAAP reports. | Monthly |  |  |  |  |
| 1. Health Insurance Provider Fee (HIPF\_ form 8963
 | Copy of IRS form 8963 as submitted to Internal Revenue Service (IRS). Revisions to the form to be submitted within 10 days of IRS submission. | Annually |  |  |  |  |
| 1. Quarterly KID NAIC Financial Report
 | Quarterly Reports must be filed. These reports shall be on the form prescribed by the NAIC for HMOs and shall be submitted to the State on or before May 15 (covering first quarter of current year), August 15 (covering second quarter of current year) and November 15 (covering third quarter of current year). Each quarterly report shall also contain an income statement detailing the CONTRACTOR(S)’ quarterly and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR(S)’ participation in the KanCare program. The second quarterly report (submitted on August 15) shall include the MLR report completed on an accrual basis that includes an actuarial certification of the claims payable (reported and unreported) and, if any, other actuarial liabilities reported. The actuarial certification shall be prepared in accordance with NAIC guidelines. The CONTRACTOR(S) shall also submit a reconciliation of the MLR report to the second quarterly NAIC report.Statement of Financial Position- 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.For Providers licensed as CONTRACTOR(S) by the Kansas Insurance Department (KID): Copies of financial reports and financial solvency reports as outlined in Section 5.13.1.F to be submitted to the KID pursuant to the T-XIX Manage Care Interagency Agreement as well as any additional reports or information required by KDHE or its sister agency, the KID. For non-CONTRACTOR(S) licensed Providers and for those providing services for Title-XXI Members, income and expense statements specific to the contracted program(s) will be required semi-annually, for the six-month period of January to June, and July to December of each contract period. | Quarterly |  |  |  |  |
| 1. Inventory Management Analysis by Claim Type
 | Summary report of all claim types received and processed. | Monthly |  |  |  |  |
| 1. Input Type Control Listings
 | Summary report of number of claims submitted via web, paper and batch. | TBD |  |  |  |  |
| 1. Records of Non-processable Claims
 | Summary report of incomplete claims lacking information to be processed. | TBD |  |  |  |  |
| 1. Exception Reports of Claims in Suspense in a Particular Processing Location for More Than a User-specified Number of Days
 | Tracking report of claims routed to different departments for adjudication. | TBD |  |  |  |  |
| 1. Electronic Submission Statistics (as defined by the State)
 | Reports of unsuccessful transmissions and claims/encounters and adjustments, errors or rejections.  | TBD |  |  |  |  |
| 1. Reports of Unsuccessful Transmissions and Claims/Encounters and Adjustments Errors or Rejections
 | Summary report to include: * Claim filing is within time limit for filing
* Logical dates of services (e.g., valid dates, not future dates)
* Service consistency with place of service/type of service
* Units/number of services performed is consistent with the span of time for the procedure
 | TBD |  |  |  |  |
| 1. Timely Claims Processing
 | Claims report to include:* Percent of claims processed within thirty (30) days
* Percent of claims processed within sixty (60) days
* Percent of claims processed within ninety (90) days
 | TBD |  |  |  |  |
| 1. Top Claims Denial Reasons
 | Report of the highest percentage for each denial reason. | TBD |  |  |  |  |
| 1. Encounter Submission Report
 | Summary report of encounters, voids and replacements, as well as held encounter reasons. | Weekly |  |  |  |  |
| 1. Pended Claims Report
 | Claims reports of pended claims to include pend reason codes. | As Needed |  |  |  |  |
| 1. KDHE Unified Log
 | Report is a log of all known provider, claims, Third Party Liability (TPL), and eligibility issues. The electronic file is shared with the CONTRACTOR(S) weekly and the MCO provides a status update each week until the issue is closed.  | Weekly |  |  |  |  |
| 1. KanCare Claims Resolutions Log
 | The KanCare Claims Resolutions Log contains a list of items that are currently in process for the fiscal agent and the CONTRACTOR(S). It provides a brief explanation of the issue and any updates with regard to needed system modifications and/or claims projects that need to be queued up for claims adjustments. The Providers have the option to submit corrected claims to expedite reprocessing or to wait for claims to be reprocessed systematically. If the system has not yet been corrected/updated, a date for reprocessing/adjusting claims will be determined once the system correction/update has been made.  | As Needed |  |  |  |  |
| 1. Encounter Resolutions Log (CONTRACTOR(S))
 | Report to list all encounter data issues and resolution dates. | TBD |  |  |  |  |
| 1. Problem Notification
 | Notification of any issue within its span of control that may jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information in said systems to include Issues affecting scheduled exchanges of data between the CONTRACTOR(S) and the State and/or its agents. Notification to include impact to critical path processes such as enrollment management and claims submission processes.Notification may be submitted via phone, fax and/or electronic mail within one (1) hour of such discovery.  | TBD |  |  |  |  |
| 1. CONTRACTOR(S) Daily Encounter Submission Report (CLM-0123-D Secured File Transfer Protocol (SFTP))
 | Report of daily encounter submissions. | TBD |  |  |  |  |
| 1. CONTRACTOR(S) Front End Billing (FEB) Pending File Report
 | Summary report of pending FEB files. | TBD |  |  |  |  |
| 1. New-Rejected and Accepted Claims
 | Report of number of FEB claims that were accepted and rejected per week. At a minimum, the report should contain:* Claim type
* CONTRACTOR(S)/SUBCONTRACTOR(S)
* Number of claims accepted
* Number of claims rejected
* Total number of claims
* Percentage of claims accepted
* Percentage of claims rejected
 | TBD |  |  |  |  |
| 1. Acceptance of FEB-Related Files
 | Report indicating when the FEB-related files were loaded into the system. | TBD |  |  |  |  |
| 1. Submission of Pre-Adjudicated Claim Copies
 | Report indicating when the pre-adjudicated claim copies were sent to the State. | TBD |  |  |  |  |
| 1. Submission of Pre-Adjudicated Claim Copies
 | Report of submissions of claims copies prior to adjudication. | TBD |  |  |  |  |
| 1. Death Data Match Reports-Providers Report
 | This report contains a list of Providers whose records were updated with a date of death. CONTRACTOR(S) is expected to review the information and end date the CONTRACTOR(S) program eligibility with the provider’s date of death. | Monthly |  |  |  |  |
| 1. Death Data Match Reports-Encounters After Date of Death (DOD) Report
 | This report contains a list of encounter claims in MMIS with dates of service after the provider’s DOD. After retrieving this report, the CONTRACTOR(S) should follow their internal process for recouping the claims. Once the claim has been recouped, the encounter would be voided from MMIS. | Monthly |  |  |  |  |
| 1. New-Monthly Claims Processing Reporting
 | Claims report to include:* Percentage of claims paid
* Percentage of claims denied
* Average days to process (electronic and paper)
* Processed less than thirty (30) days
* Processed greater than thirty (30) days
 | Monthly |  |  |  |  |
| 1. New-Monthly Claims Processing Reporting - Timely Filing Statistics
 | Claims report to include:* Number of requests received
* Number of requests completed
* Average business days to complete
* Top three reasons for timely filing bypass requests
 | Monthly |  |  |  |  |
| 1. New-Monthly Accounts Receivables (ARs) Collections
 | Accounts receivables report to include:* Number of ARs assigned for collection
* Number of new ARs assigned for the month
* CONTRACTOR(S) referral amount
* Total dollars collected
 | Monthly |  |  |  |  |
| 1. New-Adjustment or Corrected Claim Reporting
 | Claim report to include:* Number of ARs assigned for collection
* Number of new ARs assigned for the month
* CONTRACTOR(S) referral amounttotal dollars collected
 | Monthly |  |  |  |  |
| 1. Electronic Health Screen Report
 | A report that includes the names of and the cumulative number of Members for whom the plan has completed a health screen via a data review.  | Annual  |  |  |  |  |
| 1. Service Coordination Caseload Report
 | Report to include:* Number of Members enrolled in service coordination by stratification level
* Number of completed PCSP’s within required timeframes
* Number of reassessments
* Number of telephonic contacts
* Number of face-to-face contacts
* Number of Members per waiver and per level of care
* Number of Members no longer in need of LTSS
 |  |  |  |  |  |
| 1. Advance Pay Collection Referral Report
 | Report includes information regarding outstanding accounts receivable that have been referred to the CONTRACTOR(S) for collection.  | Monthly |  |  |  |  |
| 1. HCBS Provider Qualifications and Training Status
 | Provider qualifications and training records for all participating HCBS Providers that include qualification status and content of training, date(s) and participants. | Annual |  |  |  |  |
| 1. Schedule and Annual Report of Provider Training Sessions
 | A schedule of all trainings offered to Participating Providers, including in-person, internet based and other remote access trainings. The CONTRACTOR(S) shall provide an annual report which reflects the completion of these training sessions over the calendar year. | Annual |  |  |  |  |
| 1. Cultural Competency Plan
 | The Plan must include how the CONTRACTOR(S) ensures that care and services are delivered in a culturally competent manner, training, goals and an annual assessment of the plan. | 90 days post contract award and Annually thereafter |  |  |  |  |
| 1. Monitoring and Notification of Provider Qualifications
 | Describes how network provider licensure will be verified for all provider types on an ongoing basis and the timelines for notification to the State when issues are identified. | 90 days before the start of the Contract Year |  |  |  |  |
| 1. Non-Participating Provider Report
 | Number of non-participating Providers utilized, provider type, provider specialty and rationale for using in lieu of a contracted network provider.  | Quarterly |  |  |  |  |
| 1. Member Advisory Committee
 | Describes the plan for the Member Advisory Committee.  | Annually |  |  |  |  |
| 1. Member Advisory Committee
 | Summarizes activity of Member Advisory Committee.  | Quarterly |  |  |  |  |