17. Managed Care Reporting

17.1. General Information

MCOs are required to comply with all reporting requirements established by HCA as specified in the Agreement, which details requirements for timely submission, formatting, completeness and accuracy of content. MCOs are provided with State-approved instructions and templates to facilitate timely, complete, and accurate reporting. A complete list of current reports is incorporated in this Manual as 17.8.1: Turquoise Care MCO Reports.

17.2. General Requirements

HCA, at its discretion, may request information and/or data, identified as ad hoc requests. Ad hoc requests are issued to the MCOs for various reasons and information is generally requested to address a separate and distinct issue or to provide clarification on issues that fall outside the scope of reporting (i.e., provider information, claims research, NF census, etc.).

MCOs are required to implement continuous improvement processes to identify instances and patterns of non-compliance. Identified patterns of non-compliance are addressed internally by MCOs to improve overall performance and compliance.

At its discretion, HCA may, at any time, revise existing report content, and HCA may seek MCO input on proposed changes. Once HCA issues finalized Report Instructions and Templates, MCOs will have at least 14 calendar days, and additional time at HCA's discretion, to implement report content changes depending on the nature of the changes.

17.3. MCO Reporting and Intake

HCA's report management process involves the following:

- Downloading MCO report submissions via Xerox secure File Transfer Protocol (FTP) site;
- Processing MCO report submissions, resubmissions and other related documents;
- Acknowledging receipt of reports within 45 calendar days of receipt of the report upload date;
- Performing an initial quality check to ensure the MCO report is timely, accurate, complete, formatted correctly, submitted on the correct template version and is accompanied by a signed and dated Attestation;
- Recording all report review information and actions into an MCO Reports Tracking Tool;

- Assigning MCO reports to Subject Matter Experts (SMEs) who possess the knowledge and experience to conduct a thorough analysis of MCO reports and verify MCO compliance with HCA requirements and performance standards;
- Tracking and monitoring the MCO report review and data analysis process;
- Managing HCA Lead Report Reviewer timeframes; and
- Uploading HCA feedback (Acceptance, Rejection, Final Review Tool, etc.) to the FTP site.

17.4. Report Rejection

An MCO Report may be rejected, by HCA, due to the following reason(s):

- Data inaccuracies;
- Signed Attestation not included;
- Incomplete information (e.g., data missing in fields);
- Formatted incorrectly;
- Incorrect template;
- Incorrect naming convention; and/or
- Incorrect reporting period, MCO name and report run date.

The HCA Contract Manager will determine whether a Rejection is warranted, or if a technical assistance call or other solution is preferred.

17.5. MCO Report Resubmission

HCA has developed and implemented several processes (technical assistance call, self-identified error resubmission [SIER]) to allow for improvement of the MCOs' data accuracy and reporting compliance.

Technical Assistance Call Process

HCA Contract Managers and SMEs are available to provide technical assistance to MCOs in the following areas:

- Review of HCA feedback of reports;
- Discuss extension requests of report submission deadlines; and
- Press to resolve reporting concerns;

In an effort to maximize and improve MCO reporting and data efficiency levels, HCA may conduct a technical assistance call to address data related questions and concerns. This provides an opportunity for MCOs to gain valuable guidance from HCA Contract Managers and SMEs.

After a technical assistance Call is held, the HCA Contract Manager determines whether the MCO's report is Accepted or Rejected.

Self-Identified Error Resubmission

In addition to Section 4.21.1.6 of the Agreement, MCOs must upload a SIER report within the deadline specified by an HCA Contract Manager.

MCOs are required to accurately label each subsequent report submission with the appropriate version number (v2, v3, v4).

HCA Contract Managers approve all MCO Report Rejections and SIERs; manage the technical assistance call process; and direct the overall resubmission of MCO reports.

17.6. Report Revisions

HCA conducts report revisions as necessary through a formal, written process in which MCOs and end users request needed changes to data reporting metrics. This process is intended to streamline managed care reporting and reduce administrative burden by limiting data collection, where possible, to meet Federal and state requirements. Changes to HCA's managed care data reporting also support the needs of external agencies and stakeholders.

The report revision process begins with submission of a formal request to HCA. If the request is approved, the Turquoise Care Contracts Bureau will organize a revision workgroup with SMEs and report reviewers to make required revisions or modifications.

When the workgroup completes this function, a draft reporting package is submitted to MCOs for comment and testing. Comments may be rejected or accepted, resulting in additional revisions to the reporting package. HCA then issues the final reporting package to MCOs for implementation.

17.7. System Availability Reporting

MCOs must notify HCA of MCO's and its subcontractor's systems availability and performance. In the event of scheduled unavailability of critical Member and provider Internet and/or telephone-based functions and information, including but not limited to Member eligibility and enrollment systems, MCOs must notify HCA in advance via email at HSD.MCOSystemsAvail@hsd.nm.gov in order to obtain approval by HCA. In the event of an unforeseen and unscheduled inaccessibility of any critical systems, MCOs must notify HCA via email to the above address as soon as possible.

Furthermore, in the event of a problem with system availability that exceeds four hours, MCOs are directed to notify HCA immediately via email at HSD.MCOSystemsAvail@hsd.nm.gov. MCOs are to provide HCA within five business days, documentation that includes a CAP describing how MCO will prevent the problem from occurring again.

In the event of any critical systems unavailability that has been approved by HCA but the amount of downtime exceeds what was initially approved by HCA, MCOs must notify HCA immediately via email at HSD.MCOSystemsAvail@hsd.nm.gov.

During Federal and/or State Holidays and weekends, the same processes included above would apply.

For any critical Member or provider system unavailability, MCOs should also immediately contact John Padilla, MAD, at (505) 827-1340 and email him at JohnH.Padilla@hsd.nm.gov.

For any email notification pertaining to the above direction, MCOs must use the HCA developed template included in this Section as 17.8.2: Systems Availability Incident or Event Report.

17.8. Appendices

17.8.1 Turquoise Care MCO Reports

17.8.2 Systems Availability Incident or Event Report

17.8.1. Turquoise Care MCO Reports

Report No.	Report Title	Frequency	Report Objective	Comment
1	**Members Report**	Quarterly	To ensure Native American members have access to care and are receiving needed services.	
2	**Call Center Report - Monthly**	Monthly	To capture call center statistics and ensure that callers can access a call center agent in a timely manner.	
3	**Network Adequacy Report**	Quarterly	To monitor the MCO's compliance in maintaining an adequate and efficient provider network, tracking new and terminated providers and single-case agreements.	
4	**Self-directed Report**	Quarterly	To (i) monitor the amount of the annual SDCB budget used by members, (ii) identify the services that are highly utilized, (iii) identify members that have over-utilized or under-utilized their annual CB budget, and (iv) identify members whose cost of care in the community is greater than 80% of the cost of care in a private NF.	
5	**Admissions and Readmissions Report**	Quarterly	To monitor the number of members who are readmitted to a facility such as, an RTC, TFC, hospital, within 30 calendar days of a previous discharge and to track follow up appointments after discharge.	
6	**Care Coordination Report**	Quarterly	The Care Coordination report monitors assessments, ongoing care coordination activities, and changes of care coordination levels for all levels of care coordination.	**On Hold**
8	**Level of Care (LOC) Report**	Monthly	To capture data regarding the nursing facility (NF) LOC determination process including timeframes, activities of daily living, and care settings.	
9	**Agency Based Community Benefit (ABCB) Report**	Quarterly	To (i) monitor the number of members that changed to ABCB, (ii) identify the services used by members receiving ABCB, and (iii) identify members whose cost of care in the community is greater than 80% of the cost of care in a private NF.	

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Report No.	Report Title	Frequency	Report Objective	Comment
12	**Provider Satisfaction Survey Report**	Annually	To review the results from the survey, including information regarding overall satisfaction (claims, provider relations, network, utilization and quality management, pharmacy and drug benefits, and continuity of care).	
15	**Audited HEDIS Results**	Annually	To monitor and review audited HEDIS results.	
18	**UM Program Description, Associated Work Plan and Evaluation**	Annually	To monitor the MCO's UM Program Evaluation to monitor overall effectiveness, an overview of UM activities, and an assessment of the impact of the UM program on management and administrative activities. The MCO's review and analysis shall be incorporated in the development of its following year's UM Work Plan.	
19	**UM Program Evaluation**	Annually	To evaluate the overall effectiveness of UM including an overview of UM activities and an assessment of the impact of the UM program on management and administrative activities.	**LOD #29: Combined with 18**
20	**Disease Management Description and Evaluation**	Annually	To monitor and review the MCO's Disease Management program which includes a description of MCO activities regarding chronic conditions identified in the Disease Management program description. Disease Management is a component of care coordination and must include BH as part of the program.	
21	**Disease Management Annual Evaluation**	Annually	To evaluate the MCO's Disease Management program.	**LOD #29: – Combined with 20**
22	**QM/QI Program Description and Associated Work Plan**	Annually	To monitor and review the MCO's Annual QM/QI Program Description and Associated Work Plan to include goals, objectives, structure, and policies and procedures that address continuous QI for PH and BH.	
23	**QM/QI Program Annual Evaluation**	Annually	To monitor the MCO's QM/QI Program Evaluation for the previous year's activities.	
25	**CAHPS Results Report**	Annually	To review and evaluate the Consumer Assessment of Healthcare Providers and Systems (CAHPS) results report.	
27	**Activities of the Member Advisory Boards**	Semi Annually	To review Member Advisory Board meeting agendas for general MCO membership, Native American representation, BH, and CB subgroups.	**LOD #29: Report 27 Combined with 27a and 32; now semi-annually.**

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Report No.	Report Title	Frequency	Report Objective	Comment
27a	**Subgroup of the Member Advisory Board (BH, Self-directed, etc.)**	10 business days following each meeting	To Monitor the activities of subgroups of the Member Advisory Board.	**LOD #29: Combined with 27 and 32.**
31	**Health Education Evaluation Report**	Annually	To evaluate the MCO's Health Education Plan, relating to initiatives in the plan and present findings, lessons learned and performance improvement initiatives as a result of the findings.	**LOD #29: Combined with 30.**
32	**Activities of the Native American Advisory Board Report**	10 business days following each meeting	To monitor the activities of the Native American Advisory Board, including a summary of the MCO's approach to inviting Native American advisory members, the meeting agenda, minutes, attendees and scheduling of the next meeting.	**LOD #29: Combined with 27 and 27a.**
35	**Electronic Visit Verification (EVV)**	Quarterly	To review and evaluate the use of EVV systems of the MCOs.	
36	**Critical Incidents Report - Quarterly**	Quarterly	To monitor key metrics regarding critical incident reporting for specific subpopulations and the MCO's actions in response to critical incidents.	**LOD #29: Report Number changed from 36B to 36.**
37	**Grievances and Appeals Report**	Monthly	To monitor Member and provider grievances, appeals and fair hearings and to track MCO adherence to contractual timeframes.	
38	**Provider Training and Outreach Plan and Evaluation Report**	Annually	To monitor and review the MCO's plans for provider training and outreach.	
39	**Provider Training and Outreach Plan Evaluation Report**	Annually	To evaluate specific training topics such as (i) prior authorization process, (ii) claims/encounter data submission(iii) how to access ancillary providers; (iv) members rights and responsibilities; (v) quality improvement (QI) program/QI initiatives; (vi) provider and Member Appeals and Grievances; (vii) recoupment of funds processes and procedures; (viii) Critical Incident management; and (ix) EPSDT benefit requirements, including preventative healthcare guidelines.	**LOD #29B: Combined with #38**
42	**Prior Authorization Report**	Quarterly	To capture information on services requiring prior authorization and examine changes and trends in authorizations and denials of services over time.	

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Report No.	Report Title	Frequency	Report Objective	Comment
44	**Pharmacy Report**	Quarterly	To monitor pharmacy utilization and cost, including dispensing fees, over- and under-utilization of drugs including controlled substances, utilization of formulary drugs, non-formulary drugs, over the counter, generic, and brand drugs.	
45	**BH Members Services/CSA Report**	Quarterly	To monitor the number and types of members served through CSAs and the types of services provided to such members.	**On Hold Pending Revision**
47	**Claims Activity Report**	Quarterly	Claims Activity Section – To capture data related to the disposition of claims, timeliness of claims adjudication, payments on clean claims to providers, interest paid, and claim aging. This section of the report captures claims data separately for PH providers, BH providers, I/T/Us (Indian Health Service, Tribal health providers, and Urban Indian providers), and specialty-pay providers (day activity providers, assisted living providers, nursing facilities, home care agencies, and CB providers). Claims Payment Accuracy Section – To report the findings of the MCO's internal audit of quarterly claim payments and to monitor the accuracy of those claims paid.	**LOD #29 C: Frequency of submission changed from Monthly to Quarterly**
48	**Patient Centered Medical Homes (PCMH) Report**	Quarterly	To track (i) the number of PCMHs established, (ii) the number of members that were referred to and joined a PCMH, (iii) outcomes, including emergency room utilization and hospital admission and readmission, and (iv) PCMH NCQA recognition and other accreditation.	**LOD #29: Frequency of submission changed from Semi-Annually to Quarterly**
49	**Provider Network Development, Management Plan and Evaluation**	Annually	To monitor and review the MCO's plans for developing and managing its provider network to ensure all medically necessary services are accessible and available.	
50	**Provider Network Development and Management Evaluation Report**	Annually	To evaluate the Provider Network Development and Management Plan that provides information on a summary of providers, monitoring activities, contract provider issues, network deficiencies and on-going activities for provider development and expansion.	**LOD #29: Combined with 49**
51	**Provider Suspensions and Terminations Report**	Semi Annually	To monitor the suspensions and terminations of providers and the number of members impacted.	**LOD #29: Frequency of report submission changed from Quarterly to Semi-Annually**

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Report No.	Report Title	Frequency	Report Objective	Comment
53	**PCP Report**	Quarterly	To capture information regarding PCP Member ratios, open panels and assignment/change activity for non-dual members.	**LOD #29: Frequency of submission changed from Monthly to Quarterly**
55	**Geo/Access Report**	Quarterly	To monitor access to services by county and across urban, rural, and frontier counties.	
56	**Program Integrity Report**	Quarterly	To monitor fraud, waste, and abuse cases, preliminary investigations, suspicious activities, adverse actions, and financial program integrity activities of the managed care organization.	
61	**Medicaid School-Based Health Centers (SBHC)**	Quarterly	To track the quantity and types of services billed by school-based health centers.	**On Hold – LOD #29 (pending revision)**
63	**Developmental Disabilities (DDs) Specialty Dental Report**	Quarterly	To monitor dental visits for members with DDs.	
64	**Jackson Class Members Report**	Quarterly	To monitor MCO performance in processing requests for and delivering new adaptive equipment and modifications or repairs to adaptive equipment.	
66	**Health Homes (HHs) Report**	Quarterly	To track (i) the number of HHs established; (ii) the number of members referred to and joined a HH (iii) outcomes, including emergency room utilization and hospital admissions and readmissions.	**On Hold – LOD #29** **This report is in development**

17.8.2. Systems Availability Incident or Event Report

Systems Availability Incident or Event Report

MCO Name	
Report Date	

Name of System Affected	Critical or Non Critical	Functionality of Affected System	Description of Event	Extent of Data Impact/Data Loss	Event Start Date and Time	Event End Date and Time	Event Duration	Recovery Action(s)	Corrective Action Plan, If Applicable

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