Appendix E Information Technology

Contents

1. Instructions

Introduction

The purpose of this Appendix is to assess the information technology [IT] capabilities of the Applicant. This Appendix assesses six (6) key areas: Information System, Claims Processing System, Encounter Reporting and Submission System, Member Data Maintenance System, Provider Data Maintenance/PCP Assignment Systems, and Data Warehouse/Decision Support/Reporting Systems.

This Appendix is structured to enable an Applicant to indicate its existing system capabilities, the state(s) and line(s) of business where such capabilities are currently deployed, and whether a given feature or function will be made available at the time the Applicant would implement the system in Ohio.

NOTE: **The Applicant must respond based on the capabilities of the Applicant and/or the Applicant's Corporate Family. Capabilities from a Delegated Entity are NOT permissible.**

<u>Definition of Terms</u>
1. **Business Partner -** state Medicaid agency, employer or other entity that currently contracts with a managed care plan for the provision of health care services to covered members.
2. **Information System** - 'information system' used throughout this document generally refers to the system(s) that support claims and encounter processing, member data, provider data and service authorizations, unless otherwise specified.
3. **Claim**- A claim includes the following: 1) a bill for services; 2) a line item of services; or 3) all services for one recipient within a bill.
4. **Encounter**- An encounter is a record of any service provided to a member of a health plan that is submitted to a business partner for notification that: 1) the service occurred; and 2) the payment and payment arrangement associated with that service. Encounters include services: 1) paid for by health plans to providers either retrospectively through fee-for-service payment arrangements or prospectively through capitated arrangements; and 2) free immunization services that are not paid for by the health plan.

Instructions

- Read and respond to each question in the following sections. **Note: <u>All responses are subject to verification.</u>**

- To indicate that your system *as of February 2009* has a capability, enter the appropriate **state** and **line of business code** for the business partner for which the system functionality exists (e.g., in what state and for what line of business).

    – State codes are provided in the table below.

    – The state code is the common 2-alphabetical character US Postal Service code (e.g., Ohio = OH).

STATE CODES									
State	**Code**	**State**	**Code**	**State**	**Code**	**State**	**Code**	**State**	**Code**
Alabama	AL	Georgia	GA	Maryland	MD	New Jersey	NJ	South Carolina	SC
Alaska	AK	Hawaii	HI	Massachusetts	MA	New Mexico	NM	South Dakota	SD
Arizona	AZ	Idaho	ID	Michigan	MI	New York	NY	Tennessee	TN
Arkansas	AR	Illinois	IL	Minnesota	MN	North Carolina	NC	Texas	TX
California	CA	Indiana	IN	Mississippi	MS	North Dakota	ND	Utah	UT
Colorado	CO	Iowa	IA	Missouri	MO	Ohio	OH	Vermont	VT
Connecticut	CT	Kansas	KS	Montana	MT	Oklahoma	OK	Virginia	VA
Delaware	DE	Kentucky	KY	Nebraska	NE	Oregon	OR	Washington	WA
District of Columbia	DC	Louisiana	LA	Nevada	NV	Pennsylvania	PA	West Virginia	WV
Florida	FL	Maine	ME	New Hampshire	NH	Rhode Island	RI	Wisconsin	WI
								Wyoming	WY

    – There are three LOB codes:

LINE OF BUSINESS (LOB)	Code
Medicaid (TANF, ABD, SCHIP)	1
Medicare	2
Commercial	3

- If your system has a feature which is currently used in Ohio or in another state as of February 2009, and that feature *will* be made available to Ohio for regional implementation, enter an **X** in the "YES" column in the shaded area at the right under the heading that states "*Capability for Ohio will be available…*". See Example A.

- To indicate that your system does not have a feature, enter an **X** in the "NO" column under the heading "Applicant Experience". See Example B.

- If the Applicant responds "NO" (the feature/function is not available as of February 2009), but wishes to indicate that the Applicant will make a feature available at the time of Ohio regional implementation , enter an **X** in the "YES" column in the shaded area at the right under the heading that states "*Capability for Ohio will be available …*". See Example B.

- If your system does not currently have a feature, and this feature will not be made available at the time of Ohio regional implementation, enter an **X** in the "NO" column under "APPLICANT EXPERIENCE" and an **X** in the "NO" column in the shaded area at the right under the heading that states "*Capability for Ohio will be available …*" See Example C.

- Any question that requires a response cannot be left blank.

NOTE: ODJFS reserves the right to contact Applicants subsequent to application submission for clarification.

Example A

Provider Data Maintenance/PCP Assignment Systems

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on Page 7: 2-2	
			YES		NO	YES	NO
			State ID	LOB ID			
7		*Does the Applicant's member data maintenance system include <u>all</u> of the following core system capabilities?*	CA 1 OH 1			X	
		▪ Perform duplicate checking ▪ Assign unique ID numbers for each member and dependent ▪ Cross-reference a member's current Medicaid number with any previous numbers					

The response for item # 7 in this example indicates ***the Applicant's system has feature(s)*** in California (CA) & Ohio (OH) for the Medicaid program (LOB code 1) as of February 2009, and that the function(s) ***will*** be available and fully operational for Ohio regional implementation.

DO NOT ANSWER THE BLOCK OUT AREA TO THE RIGHT OF THE FEATURE LISTING

Example B

Provider Data Maintenance/PCP Assignment Systems

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on Page 7: 2-2	
			YES	NO			
			State ID	LOB ID		YES	NO
3		*Does your provider data maintenance system support PCP assignment and reporting, including the following capabilities:*					
		▪ Ability to automatically identify the patient's elected PCP?			**X**	**X**	

The response above indicates that your system *does not have this feature as of February 2009*, but that the feature *will* be available and fully operational for Ohio regional implementation.

Example C

Provider Data Maintenance/PCP Assignment Systems

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on Page 7: 2-2	
			YES		NO	YES	NO
			State ID	LOB ID			
3		*Does the Applicant's provider data maintenance system support PCP assignment and reporting, including the following capabilities:*					
		▪ Ability to automatically identify the member's elected PCP?			**X**		**X**

The response above indicates that the Applicant's system ***does not have the feature as of February 2009***, and that the feature will ***not*** be available for Ohio regional implementation.

References

When the Applicant has completed all the questions for each section, please enter information for one reference contact for each business partner [i.e., state and line of business] for which the system is currently deployed. Two blank tables have been provided for this purpose. Please provide **no more than two** references.

2-1. Applicant Name : _____

2-2. IT Implementation Time Frame

Item	Agreement Reference	QUESTION	RESPONSE
1	Request for Applications SFY 2009 MCP Provider Agreement for the Aged, Blind & Disabled Population (ABD) [See Applicant Library] Supporting technical specifications and methods [See Applicant Library]	*Indicate the date the Applicant's information system will meet 1) all Ohio Medicaid managed care program information system requirements; 2) be fully operational; and 3) have the capacity to serve the membership designated by this RFA.* *Note*: The response to this question is incorporated and referred to in the last shaded column of all subsequent tables. When the Applicant indicates that a system feature or function is available, it will be available and fully operational for Ohio regional implementation on this date.	_____ **Date (mm/dd/yyyy)**

3. Information System

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on Page 7: 2-2	
			YES		NO		
			State ID	LOB ID		YES	NO
1		Does the Applicant have a program in place to keep the Applicant's information technology staff turnover rate for the past 12 months lower than 25%?					
2		Is the information system (i.e., system(s) that support claims and encounter processing, member data, provider data and service authorizations) a single, integrated system developed by a single vendor rather than a consolidation of several vendors' software packages?					
3		Does the information system use a relational database as its primary database?					
4		Does the Applicant employ methodologies, procedures, documentation standards and appropriate user (i.e., business partner) involvement in testing modifications and enhancements, including unit, system, integrated (end-to-end), and business user acceptance and end-to-end testing?					
5		As of February 2009, is the Applicant's core information system capable of supporting applications of the size, complexity and transaction volumes required for monthly enrollment of at least 10,000 members for each business partner for which the Applicant has been contracted to provide services?					

Information System References

For each account (state and line of business – LOB) listed for the Applicant's responses to questions regarding the Information Systems, please identify a reference contact, including name, title, organization, phone number, email address, and mailing address.

Reference	Reference
State/LOB Code:	State/LOB Code:
Health Plan Name [i.e. Name of the Applicant as it appears on the contract with the Business Partner]	Health Plan Name [i.e. Name of the Applicant as it appears on the contract with the Business Partner]
Business Partner	**Business Partner**
Name:	**Name:**
Title:	Title:
Organization:	Organization:
Phone Number:	Phone Number:
Email Address:	Email Address:
Mailing Address:	Mailing Address:

4. Claims Processing System

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on Page 7: 2-2	
			YES	NO		YES	NO
			State ID	LOB ID			
		The Applicant's claims processing system possesses sufficient capacity as of February 2009 to handle program adjustments needed by its business partner in ongoing operations. Please address the following:					
1		▪ Are EDI claims subjected to the same edits as claims processed internally (i.e., paper & data entry claims) by the claims processing systems?					
2		▪ Does the Applicant's claims processing systems contain sufficient capabilities for generating audit trails, date and time of modifications, and user identification?					
3	Appendix C, (30)(b)	▪ Does the Applicant's claims processing system include the capacity to electronically accept and adjudicate claims, and notify providers of status (paid, denied, pended) within 30 days of submission?					

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on Page 7: 2-2	
			YES	NO		YES	NO
			State ID | LOB ID				
4		*Does the Applicant's claims processing system incorporate **all** of the following functionalities?*					
	Appendix C, (30)(b)	▪ Batching, routing, and tracking of claims and correspondence. ▪ Claims unbundling and rebundling. ▪ Generation of explanation of benefits, and electronic remittance advices monthly or more frequently, including claims status within a month of submission.					
5		*Does the Applicant's claims processing system incorporate **all** of the following features?*					
		▪ Immediate, online adjudication of claims, claims correction, void and adjustment capabilities. ▪ Real-time posting and adjustment of benefit limits (e.g., visit/dollar limits). ▪ Automated check reconciliation procedures.					
6		Does the Applicant's claims processing system identify services included in capitated arrangements and not available for fee for service reimbursement for each individual provider?					
7		Does the Applicant's claims processing system perform coordination of benefits (COB) and subrogation, including third party liability (TPL), processing Medicaid as a secondary payer?					

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on Page 7: 2-2	
			YES		NO		
			State ID	LOB ID		YES	NO
8		*Does the Applicant's claims processing system provide for inventory management of claims and encounters, including all of the following?*					
		▪ Automated tracking of claims and encounters as they move through processing areas (mailroom, imaging, data entry, processing, review, payment, etc.).					
		▪ Tracking of paper and EDI claims and encounters, including those submitted by vendors, in each processing area in a consolidated report.					
9	Appendix J, (4)	*Do the Applicant's actual performance results for the past 12 months meet or exceed all of the following expectations:* For timeliness of payment of clean claims**:* — 90% of clean claims* within 30 days of receipt *and* — 99% of clean claims* within 90 days of receipt (see formula for calculation**).					

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on Page 7: 2-2	
			YES		NO	YES	NO
			State ID	LOB ID			
		*A clean claim is a claim that can be processed without obtaining additional information from the provider of a service or from a third party. Clean claims do not include payments made to a provider of service or a third party where the timing of payment is not directly related to submission of a completed claim by the provider of service or third party (e.g., capitation). A clean claim also does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. **(# clean claims paid within X days/ # clean claims received)					
10		Does the Applicant's claim processing system provide for immediate electronic notification for providers at the time of claims submission regarding payment, denial and pend status of submitted claims?					

Claims Processing System References

For each account (state and line of business – LOB) listed for the Applicant's responses to questions regarding the Claims Processing System, please identify a reference contact, including name, title, organization, phone number, email address, and mailing address.

Reference	**Reference**
State/LOB Code:	State/LOB Code:
Health Plan Name [i.e. Name of the Applicant as it appears on the contract with the Business Partner]	Health Plan Name [i.e. Name of the Applicant as it appears on the contract with the Business Partner]
Business Partner	**Business Partner**
Name:	**Name:**
Title:	Title:
Organization:	Organization:
Phone Number:	Phone Number:
Email Address:	Email Address:
Mailing Address:	Mailing Address:

5. Encounter Reporting and Submission System

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on Page 7: 2-2	
			YES		NO	YES	NO
			State ID	LOB ID			
1		Does the Applicant have the ability to submit encounter data files to business Partners via the business partners' specified format <u>and</u> via 837 EDI encounter transactions, including the ability to void and replace encounters?					
2	Appendix C, (30) (c); Appendix L, (1)(a)	Does the Applicant verify that <u>all</u> encounters [including those processed by vendors] are included in data submissions to business partners?					
3		Does the Applicant's encounter data submission process edit and eliminate duplicate encounters prior to submission to business partners?					
4	Appendix C, (30)(c)	Does the Applicant have the ability to submit encounters according to requirements for format, content, timeliness, accuracy and completeness specified by business partners?					
5	Appendix L, (1)(a)	Does the Applicant verify that all data required by business partners are included on capitated or zero-pay claims and encounters, including those submitted by contracted vendors?					

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on Page 7: 2-2	
			YES	NO		YES	NO
			State ID	LOB ID			
6		▪ Does the Applicant edit encounters per business partner specifications prior to submission to business partners?					
7		▪ Does the Applicant's encounter submission and reporting processes have capabilities to track, control and balance the submissions of accepted, denied and rejected encounters, and totals for all submissions?					
8		▪ Does the Applicant's encounter data submission and reporting processes track encounters that are corrected, resubmitted and subsequently accepted or rejected upon resubmission, including processes to prevent submission of duplicate encounters?					
9		▪ Does the Applicant perform quality check analyses on all encounters [including those processed by vendors] prior to the submission to business partners?					
10		▪ Does the Applicant's encounter data submission and reporting processes have the ability to reconcile encounters with the business partners encounter data system?					

Encounter Reporting and Submission System References

For each account (state and line of business – LOB) listed for the Applicant's responses to questions regarding the Encounter Reporting and Submission System, please identify a reference contact, including name, title, organization, phone number, email address, and mailing address.

Reference	Reference
State/LOB Code:	State/LOB Code:
Health Plan Name [i.e. Name of the Applicant as it appears on the contract with the Business Partner]	Health Plan Name [i.e. Name of the Applicant as it appears on the contract with the Business Partner]
Business Partner	**Business Partner**
Name:	**Name:**
Title:	Title:
Organization:	Organization:
Phone Number:	Phone Number:
Email Address:	Email Address:
Mailing Address:	Mailing Address:

6. Member Data Maintenance System

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on *Page 7: 2-2*	
			YES	**NO**			
			State ID / *LOB ID*			*YES*	*NO*
		Does the Applicant's member data maintenance system meet the following data receipt, submission and reconciliation requirements?					
1	Appendix C, (30)(b)	▪ Ability to accept premium payment and enrollment maintenance transactions in HIPAA 820 and 834 formats?					
2	Appendix C, (29)(b)	▪ Ability to electronically accept and maintain membership monthly as specified by your business partner?					
3	Appendix C, (29)(b)	▪ Ability to accept and reconcile monthly premium and membership data with the monthly remittance advice?					
4	Appendix C, (29)(c)	▪ Ability to accept daily or weekly updates of enrollment and disenrollment transactions in addition to the monthly eligibility file load?					
5	Appendix C, (29)(g)	▪ Ability to accept and maintain pending (i.e., an eligible individual subsequent to plan selection but prior to their membership effective date) member-provided information, such as the primary care provider (PCP) choice, hospitalization reporting, etc.?					

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on Page 7: 2-2	
			YES	NO		YES	NO
			State ID | LOB ID				
6	Appendix C, (29)(d)	▪ Ability to identify new members hospitalized prior to and remaining hospitalized on the effective date of MCP membership?					
7		▪ Does the Applicant's member data maintenance system perform duplicate checking and assign unique ID numbers for each member and dependent?					
8		▪ Does the Applicant's member data maintenance system maintain multiple occurrences of other (i.e., non-Medicaid including private pay) insurance information?					
9		▪ Does the Applicant's member data maintenance system process terminations and retroactive terminations accurately?					
10	Appendix C, (20)	▪ Does the Applicant's member maintenance system maintain members' primary language information (PLI) as specified by the business partner?					

Member Data Maintenance System References

For each account (state and line of business – LOB) listed for the Applicant's responses to questions regarding the Member Data Maintenance System, please identify a reference contact, including name, title, organization, phone number, email address, and mailing address.

Reference	**Reference**
State/LOB Code:	State/LOB Code:
Health Plan Name [i.e. Name of the Applicant as it appears on the contract with the Business Partner]	Health Plan Name [i.e. Name of the Applicant as it appears on the contract with the Business Partner]
Business Partner	**Business Partner**
Name:	**Name:**
Title:	Title:
Organization:	Organization:
Phone Number:	Phone Number:
Email Address:	Email Address:
Mailing Address:	Mailing Address:

7. Provider Data Maintenance/PCP Assignment Systems

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on Page 7: 2-2	
			YES		NO	YES	NO
			State ID	LOB ID			
1		Does the Applicant's provider data maintenance system include the ability to receive, and reconcile, from business partners a monthly master provider file containing Medicaid provider numbers, provider name and provider status?					
2	Appendix H, (3)	Does the Applicant's provider data maintenance system have the ability to capture PCP (primary care provider) capacity?					
3		Does the Applicant's provider data maintenance system provide automated maintenance of provider affiliations and locations, tracking provider's affiliations with multiple groups, multiple owners, multiple offices, and hospital affiliations?					
4		Does the Applicant's provider data maintenance system maintain provider status, credentialing, licensing and contract status (including associated effective date and end date)?					
5	Appendix H, (5)	Does Applicant's provider data maintenance system have the ability to produce annual provider directories in the format specified by business partners?					
6		Does Applicant's provider data maintenance system provide the automated ability to process changes in provider ownership and all activity performed by prior ownership without re-entry of data?					

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on *Page 7: 2-2*	
			YES		**NO**		
			State ID	*LOB ID*		*YES*	*NO*
7	Appendix H, (5)	Does Applicant's provider maintenance system provide internet access to provider directory information?					
8		Does Applicant's provider data maintenance system support Primary Care Provider (PCP) assignment, identify the patient's elected PCP, and track member-designated PCP data?					
9		Does Applicant's provider data maintenance system include the ability to capture information specific to provider's practice, including office hours, languages spoken, specialties and access for disabled patients?					
10	Appendix L (4)	Ability to submit and reconcile a monthly Primary Care Provider (PCP) data file in the format specified by the business partner to the business partner's data system, including the ability to submit changes/updates to PCP assignments, corrections to PCP assignments and resubmit rejected PCP data?					

Provider Data Maintenance/PCP Assignment System References

For each account (state and line of business – LOB) listed for the Applicant's responses to questions regarding the Provider Data Maintenance system, please identify a reference contact, including name, title, organization, phone number, email address, and mailing address.

Reference	Reference
State/LOB Code:	State/LOB Code:
Health Plan Name [i.e. Name of the Applicant as it appears on the contract with the Business Partner]	Health Plan Name [i.e. Name of the Applicant as it appears on the contract with the Business Partner]
Business Partner	**Business Partner**
Name:	**Name:**
Title:	Title:
Organization:	Organization:
Phone Number:	Phone Number:
Email Address:	Email Address:
Mailing Address:	Mailing Address:

8. Data Warehouse/Decision Support/Reporting Systems

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on *Page 7: 2-2*	
			YES State ID / LOB ID	**NO**		**YES**	**NO**
1		*Does the Applicant have a data warehouse with <u>all</u> of the following capabilities?*					
		▪ Ability to define new data fields to the data warehouse					
		▪ Access to new data fields populated with historical data where available					
		▪ Ability to query a claim line item with the associated, applicable prior authorization					
2		Does the Applicant's automated reporting system have the ability to report HEDIS measures according to the current and future HEDIS administrative reporting guidelines?					
3		Does the Applicant produce automated reports to track specific performance standards for individual processors for their timeliness and accuracy [e.g., claims and payment processing]?					

Item	ODJFS MCP ABD Provider Agreement Reference Only	QUESTION	APPLICANT EXPERIENCE			Capability for Ohio will be available on the date indicated on *Page 7: 2-2*	
			YES		NO		
			State ID	LOB ID		YES	NO
4		*Does the Applicant have a Decision Support System that supports **all** of the following capabilities?*					
		▪ Ability to produce the following reports, as defined by business partner: − rates of care/access to care − quality & performance measurement − outcomes measurement ▪ Support for current industry grouping standards (ETG, ERG, DRG, RVU).					
5	Appendix L (2)	Does the Applicant's care management information system have the ability to maintain and track member care management data? Does the Applicant also has the ability to submit and reconcile a monthly Care Management data file in the format specified by the business partner to the business partner's Care Management data system, including the ability to submit changes/updates to care management data, corrections to care management data and resubmit rejected care management data?					

Data Warehouse/Decision Support/Reporting System References

For each account (state and line of business – LOB) listed for the Applicant's responses to questions regarding the Data Warehouse/Decision Support/Reporting Systems, please identify a reference contact, including name, title, organization, phone number, email address, and mailing address.

Reference	Reference
State/LOB Code:	State/LOB Code:
Health Plan Name [i.e. Name of the Applicant as it appears on the contract with the Business Partner]	Health Plan Name [i.e. Name of the Applicant as it appears on the contract with the Business Partner]
Business Partner	**Business Partner**
Name:	**Name:**
Title:	Title:
Organization:	Organization:
Phone Number:	Phone Number:
Email Address:	Email Address:
Mailing Address:	Mailing Address: