CABINET FOR HEALTH AND FAMILY SERVICES

DEPARTMENT FOR MEDICAID SERVICES

EXAMINATION OF PASSPORT HEALTH PLAN

MAY 25, 2012

Kentucky UNBRIDLED SPIRIT

Myers and Stauffer LC
Certified Public Accountants

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GLOSSARY

The table below contains a list of terminology, abbreviations, and references (collectively "Items") that may be used throughout this report.

Key Word or Abbreviation	Description of Item, as used in this report
Ambulatory Care Building (ACB)	University of Louisville Hospital's Ambulatory Care Building is located at 550 Jackson Street, Louisville, Kentucky, on the University of Louisville's Health Sciences Campus.
AmeriHealth Mercy Health Plan (AMHP)	The health plan Subcontractor and/or third-party administrator under an agreement with University Health Care, Inc., doing business as Passport Health Plan, to perform certain of its administrative and operational functions.
Audit (or Engagement) Window	The period covered by or included in the analytical activities of this engagement to conduct a Medicaid Managed Care Operations Examination (please also refer to "Examination" below). The audit window includes State Fiscal Years (SFYs) 2009 through 2011, as well as substantive changes or improvements made after SFY 2011 but prior to the completion of analytical activities.
CMS	The Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration.
Contract	The Contract between the Department and the University Health Care, Incorporated and any executed amendments.
Department or DMS	The Commonwealth of Kentucky, Department for Medicaid Services in the Cabinet for Health and Family Services.
Examination, Examination of Passport, or Medicaid Managed Care Operations Examination	These terms and activities have been defined by the Department at RFP 746 1100000226, and do not mean an "audit" or "examination" as those terms are used and defined in the accounting profession. This engagement does not include attestation services. Myers and Stauffer was not engaged to express an "opinion" (as defined in the accounting profession) on the Medicaid Managed Care Operations or on Passport Health Plan, and no such opinion is expressed. This engagement is performed under the American Institute of Certified Public Accountants code of professional conduct for consulting engagements. Myers and Stauffer performed this engagement under the Direction of the Department, who has made all management decisions. The Department is responsible for the oversight of the Medicaid Managed Care Operations and Passport Health Plan and for determining the sufficiency of the tasks and analyses completed for this engagement. Notwithstanding the above, it is acknowledged that the terms "review," "examine," "examination," or "audit," may be used interchangeably by others to describe the services provided under this engagement.

Key Word or Abbreviation	Description of Item, as used in this report
Faculty Physicians	The entities and/or corporations including MSPA Services, Inc., (a.k.a. MSPA or Medical School Practice Association); University Physicians Group, Inc. (a.k.a. UPG or UofL Health Care); UPA Services, Inc. (a.k.a., UPA or University Physicians Associates); and University of Louisville Physicians, Inc. (a.k.a. ULP); comprised of certain University of Louisville faculty physicians.
Intensive Documentation Review (IDR)	A process used by Myers and Stauffer to facilitate understanding of data submitted by UHC, to have subject matter experts address program components, and to resolve apparent inconsistencies in certain data submitted by UHC.
Jewish Hospital and St. Mary's Healthcare Services	A Kentucky-based hospital system and a Passport Health Plan sponsoring organization.
Kentucky Health Care Partnership Program	The Kentucky Medicaid Health Care Partnership Program prepaid capitation managed care system created and implemented in accordance with the term and conditions of the 1115 Partnership Waiver granted by CMS.
Landmark Healthcare Facilities, LLC	A Milwaukee, Wisconsin, located corporation that develops physician office buildings and clinics, ambulatory care and surgery centers, cardiac and cancer centers, imaging centers, fitness and women's centers and laboratories.
Landmark Healthcare Properties Fund, LLC	A Milwaukee, Wisconsin, located corporation that finances, owns, and/or manages health care practice buildings.
Louisville-Jefferson County Primary Care Association	A provider industry association and a Passport Health Plan sponsoring organization.
Myers and Stauffer LC (MSLC)	A Certified Public Accounting and consulting firm engaged by the Kentucky Department for Medicaid Services to perform the services described in Request for Proposal 746 1100000226.
National Committee for Quality Assurance (NCQA)	An organization that sets standards, and evaluates and accredits health plans and managed care organizations.
Norton Healthcare	A Kentucky-based hospital system and a Passport Health Plan sponsoring organization.
Passport Health Plan (PHP or Passport)	The assumed name under which University Health Care, Inc., conducts business as a provider-owned licensed health maintenance organization responsible for providing services to the enrolled Medicaid members in Region 3. Also referred to as "PHP", "Passport" or the "health plan."

Key Word or Abbreviation	Description of Item, as used in this report
Per Member Per Month (PMPM)	An amount per member per month, which is typically based on either revenue or cost. Revenue or cost for a given month is divided by unique count of member for the given month. PMPM is a normalized measure of comparison.
Request for Proposal (RFP)	Request for Proposal 746 1100000226 (Medicaid Managed Care Operations Examination) is the procurement conducted by the Commonwealth of Kentucky, Cabinet for Health and Family Services, Department for Medicaid Services to procure the services of a qualified contractor to conduct an examination of Passport and its subcontractors. The RFP was issued on 2/18/2011 with a closing date of 3/18/11.
Subcontractor	Any person or entity which contracts directly or indirectly, or otherwise agrees, to perform any function, or to support performance of any function, for the purpose of fulfilling [PHP]'s obligations under this contract or the Partnership Program including, but not limited to, provision of any administrative, support, or health care services, or to provide any material in support of those services.
University Faculty Office Building LLC	A foreign limited liability company registered with the Kentucky Secretary of State, comprised of members University Physicians Group, Inc., and Landmark Healthcare Properties Fund, LLC.
University Faculty Practice Building	The building located at 401 E Chestnut Street, Louisville, Kentucky 40202, a.k.a. FPB and University of Louisville HealthCare Outpatient Center, on the University of Louisville's Health Sciences Campus.
University Health Care, Inc. (UHC)	The legal entity doing business as Passport Health Plan.
University Medical Center (UMC)	University Medical Center is a private corporation that operates the University of Louisville Hospital. UMC is a Passport Health Plan sponsoring organization.
University of Louisville Medical School Practice Association (MSPA)	An association of University of Louisville faculty physicians and a Passport Health Plan sponsoring organization.

PREAMBLE

This report addresses the operation and administration of the Passport Health Plan for the period July 1, 2008 through June 30, 2011 or State fiscal year 2009 through 2011. As information became available, we also attempted to identify significant changes that occurred after June 30, 2011 but prior to the last date of analytical activities.

As a result of Governor Beshear's Corrective Action Plan, contractual changes required by the Department for Medicaid Services, and other self-initiated improvements, the Passport Health Plan has undergone a substantial transformation of their business model. Some of the more noteworthy changes are as follows:

- As of July 1, 2011, approximately 200 AMHP employees became UHC employees, including management and other key positions.
- Management has completed a contractual change in their relationship with AMHP, moving from an integrated administrator model to a traditional third-party administrator role.
- The health plan has developed policies and procedures for each functional area of the health plan.
- Management of the health plan evaluated staffing and reduced the number of positions, resulting from both a reassessment of personnel needs, as well as other changes as a result of a non-Medicaid line of business.
- Management of the plan has established identifiable divisions of labor, responsibilities, controls and oversight responsibilities for key personnel.
- The Board governance structure has been changed by electing a new Chairman, changing the membership of the Board by adding community Board members including 4 from rural counties outside of Jefferson County and the restructuring of the Board committees by establishing a Nominating and Governance Effectiveness Committee, Compliance Committee and Executive Compensation Committee and making the Grant Committee a subcommittee of the Finance Committee.

For purposes of this document, the terms University Health Care, Incorporated ("UHC"), Passport Health Plan ("Passport" or "PHP"), and "the health plan" are used interchangeably and refer to the same entity, unless noted otherwise.

PROJECT BACKGROUND

In 1997, CMS granted the Commonwealth of Kentucky a waiver of the Medicaid rules pursuant to Section 1115 of Title XIX of the Social Security Act as amended, to allow the Medicaid program to develop a pilot risk-based managed care program. This program was named the Kentucky Medicaid Health Care Partnership Program.
The goals of the program included the following three guiding principles:

- To provide quality care for Medicaid-eligible recipients based on a per member per month managed care rate;
- To provide Medicaid recipients affordable and accessible medical care in their community; and
- To capitalize on existing networks of family care practitioners, specialists, and acute care facilities.

A partnership of Medicaid providers was incorporated in 1996 as University Health Care, Incorporated, doing business as Passport Health Plan. This organization (#0409920) was registered with the Kentucky Secretary of State as a for-profit entity. University Health Care Incorporated (UHC) was licensed in the Commonwealth of Kentucky as a health maintenance organization in 1997. The health plan, known as Passport Health Plan, began enrolling Medicaid members in the fall of 1997. Hereinafter, the terms University Health Care, Inc., UHC, Passport Health Plan, Passport and PHP are used interchangeably and refer to the same entity.

Approximately twenty-one months after their original incorporation, University Health Care Incorporated amended their Articles of Incorporation and became a Section 501(c)(3) tax-exempt entity under the Internal Revenue Code. This organization (#0440881) was registered with the Kentucky Secretary of State as a not-for-profit entity as of October 31, 1997. Passport Health Plan was re-licensed by the Kentucky Department of Insurance as a nonprofit health maintenance organization on October 1, 2000.

Since that time, the Partnership Program has operated as Passport Health Plan, a provider-sponsored health maintenance organization. A provision of the federal waiver required that a partnership of providers would be utilized to offer managed care services and administer the program within Region 3 of the Commonwealth, which includes the 16-county Louisville metropolitan area.

The partnership of providers includes the University of Louisville Medical School Practice Association, the University of Louisville Medical Center, Jewish and St. Mary's Healthcare, Norton Healthcare Inc., and the Louisville/Jefferson County Primary Care Association (which includes the Federally Qualified Health Centers and the Louisville Metropolitan Department of Health and Wellness). This Medicaid managed care region

has established a provider network within Louisville and surrounding counties that is comprised of hospital systems, primary and specialty care physician networks, pharmacies, and other providers that deliver covered services to enrolled Medicaid members. The health plan serves approximately 170,000 members in the following counties: Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington.

The operation of the health plan is guided primarily by the contract between DMS and UHC, as well as numerous other regulations and statutes imposed by the Commonwealth of Kentucky and applicable federal agencies. The health plan must continue to meet all applicable requirements in the areas of organizational structure, licensure, finance, network adequacy, member access, client relations, enrollment functions, service delivery, utilization management, claims adjudication, contractual performance, quality improvement projects, and reserve requirements among others.

Passport Health Plan is accredited by the NCQA, which is a private, 501(c)(3) not-for-profit organization "dedicated to improving health care quality". The NCQA is widely recognized within the health insurance industry[1] as the standard for health plan accreditation. NCQA currently ranks Passport Health Plan as the 13th highest scoring Medicaid Health Plan for 2011-2012 based on NCQA's criteria and performance measurement of Consumer Satisfaction, Prevention, and Treatment[2].

In the spring of 2010, the Commonwealth of Kentucky Auditor of Public Accounts (APA) initiated an examination of University Health Care Incorporated to address "issues concerning certain financial activity of Passport Health Plan related to its affiliation with the University of Louisville and the Commonwealth of Kentucky". The APA indicated that the "purpose of [their] examination to address specific issues and questions related to University Health Care". The APA released a report of their findings on November 9, 2010[3].

[1] See http://www.ncqa.org/

[2] http://www.ncqa.org/LinkClick.aspx?fileticket=DOxc6Y2kiy8%3d&tabid=1424

[3] See http://www.auditor.ky.gov/Public/Audit_Reports/Archive/2010PassportHealthPlanreport.pdf

On the day the APA report was released, Governor Beshear issued the following statements[4]:

> *Governor Steve Beshear has ordered Passport Health Plan to work with the Cabinet for Health and Family Services (CHFS), the Department for Medicaid Services (DMS) and the Department of Insurance to immediately address issues raised in a report released today by the Auditor of Public Accounts (APA). The issues relate to governance, lack of internal controls and transparency, excessive spending and conflicts of interest by Passport officials.*
>
> *……I am calling today for Passport to take immediate steps to review its management and cease spending a single taxpayer dollar that is not absolutely necessary to provide quality health care services to Medicaid-eligible recipients.*

Governor Beshear further directed the development of "an immediate plan to correct the practices addressed in the audit and tighten controls of the program."

Passport Health Plan has completed a transformation of their business model as a result of the changes required from the Governor's Corrective Action Plan. Unless otherwise noted, the observations, findings and recommendations included in this report are specific to the period under examination.[5]

[4] To review the full press release please see http://chfs.ky.gov/news/passport+audit.htm?wbc_purpose=basic&wbcmode=presentationunpublished

[5] Myers and Stauffer has not been engaged to perform testing, monitoring or reporting on the corrective action plan.

INTRODUCTION

Myers and Stauffer LC (MSLC) was engaged by the Department for Medicaid Services to perform an examination of Passport Health Plan and its subcontractors and related subjects. The scope of the engagement was defined by the Department for Medicaid Services and does not mean an "audit" or "examination" as the terms are used and defined in the accounting profession. This engagement does not include attestation services. Myers and Stauffer was not engaged to express an "opinion," as that term is used in the accounting profession and no such opinion is expressed. The Department determined that the examination should include the following subjects:

- A comprehensive assessment of "Kentucky's sole-source, non-competitive managed-care provider for Region 3, University Health Care, d.b.a. Passport Health Plan";
- The efficiency and "appropriateness of expenditures as necessary to provide quality health care services to Medicaid eligible individuals"; and
- Issues related to fraud, waste, abuse and contract compliance.

This engagement was performed under the American Institute of Certified Public Accountants code of professional conduct for consulting engagements. Myers and Stauffer performed the engagement activities under the direction of the Department, which made all management decisions.

The Department is responsible for the oversight of the Passport Health Plan and for determining the sufficiency of the tasks and analyses completed for this engagement.

The audit window of the examination includes SFYs 2009 through 2011, but also considers any substantial changes to the Passport Health Plan business model, service delivery, or administrative changes that may have been implemented by PHP subsequent to June 30, 2011.

The examination included five primary objectives:

Objective 1 - Appraise the appropriateness and effectiveness of Passport's managed care operations and those of other subcontractors, including AmeriHealth Mercy, serving Region 3 patients;

Objective 2 - Review Passport's use of, and relationship with, Passport subcontractors / other business entities;

Objective 3 - Analyze the methodology for classifying expenditures as medical services;

Objective 4 - Examine the grant award process by Passport, AmeriHealth Mercy and other subcontractors; and

Objective 5 - Review health care utilization practices by Passport and subcontractors that may influence utilization; review use of incentives and methodologies relied upon in establishing incentive structures.

Each of these five objectives, including their sub-components, was addressed according to the deliverable schedule presented below. The section numbers and descriptions correspond to the deliverable requirements as specified in RFP746 1100000226, pages 18 through 23.

		Deliverable Group		
Section	**Brief Description**	**Group 1**	**Group 2**	**Group 3**
2.02.01 A	Passport Business Plans	√		
2.02.01 B	Comparison of Operations	√		
2.02.01 C	Revenue, Compensation, and Expenditures		√	
2.02.01 D	Complaints and Concerns	√		
2.02.01 E	Business Relationships	√		
2.02.01 F	Supplemental Payments		√	
2.02.02 A	Lines of Business	√		
2.02.02 B	Best Practices	√		
2.02.02 C	Selection of Subcontractors	√		
2.02.02 D	Methodology of Payment	√		
2.02.02 E	Validity of Incentives	√		
2.02.03 A-C	Analysis of Expenditures			√
2.02.04 A-D	Grants and Donations		√	
2.02.05 A-B	Utilization Practices			√

General Approach and Methodology

Baseline Data Collection

Members of the Department's executive team met with Myers and Stauffer for the initial project meeting on August 10, 2011. During that meeting, the Department, Myers and Stauffer, and Passport Health Plan held an initial discussion regarding the scope, audit window, approach, resource needs, and general time line.

A second meeting with PHP was held on August 24, 2011 to discuss the Passport business model. Members of the health plan's management, the Department, and Myers and Stauffer participated in the teleconference. PHP presented several slides that described the roles and responsibilities of the significant contributors to their business model.

Myers and Stauffer met with the Cabinet Secretary Miller on August 29, 2011 to discuss the examination process. Secretary Miller provided documentation submitted to the Department from Senator Tim Shaughnessy and indicated that DMS wished to evaluate the veracity of the potential public interest concerns raised in that documentation. Secretary Miller indicated that DMS was available and at our disposal to assist in obtaining data and documentation as needed to perform that evaluation. The Secretary further instructed Myers and Stauffer to work closely with the Department's leadership on data and documentation requests, and when possible, provide as much time as could be permitted for PHP to respond.

Based on these parameters, Myers and Stauffer prepared two baseline data requests that required an extensive amount of source material from PHP. Both baseline data requests were sent to PHP on September 2, 2011 and requested that University Health Care, Incorporated, subcontractors and vendors submit the requested materials by September 8, 2011 and September 9, 2011, respectively.

In addition to the two baseline data requests, a Notification of On-Site Activities was sent to Passport and to AmeriHealth Mercy Health Plan (AMHP). The notification indicated that onsite activities would occur at the PHP office in Louisville, Kentucky and at the AMHP office in Philadelphia, Pennsylvania on September 12 and September 13, 2011. Excerpts of the notification letter are included in the following two paragraphs:

> This letter serves as notification that, as part of this initiative, we will be performing on-site activities at the Passport office in Louisville Kentucky and at the offices of AmeriHealth Mercy in Philadelphia, Pennsylvania from September 12 to September 13, 2011. Due to the limited amount of time to complete the required analyses, we are, unfortunately, unable to offer flexibility to you with these dates. However, we will do our best to accommodate scheduling conflicts or other matters of availability affecting key staff.

> Enclosed with this announcement is an initial list of data and documentation that should be available upon our arrival. Materials should be organized in such a manner to as facilitate ease of identification.

Myers and Stauffer's audit teams arrived on-site at PHP and AMHP offices as scheduled.

On-site teams completed the following activities:

1) Participated in an entrance meeting
2) Toured the facilities
3) Inspected available data and documentation
4) Conducted interviews with selected health plan staff
5) Prepared a list of missing/incomplete or additional materials required, or additional interviews to be scheduled (to be completed via telephone)
6) Held a closing meeting

Over the course of our initial site visits, follow-up interviews, conference calls and multiple follow-up visits to PHP, the engagement team completed 24 interviews, as noted in the following table.

		No. of Interviews		
Personnel Group	**Mode**	**Requested**	**Completed**	**Percent**
AMHP	In Person	4	4	100%
AMHP	Telephone	3	3	100%
PHP	In Person	10	10	100%
PHP	Telephone	3	3	100%
PHP	In Person	2	2	100%
Former Employees	In Person	3	3	100%
Total		**24**	**24**	**100%**

In addition to these 24 interviews, numerous interviews were completed based on specific subject matter. Information regarding those interviews is presented in the applicable sections of this report.

The methodology utilized in the inspection, evaluation, and analysis of source material employed various techniques, such as inquiry, testing, compliance considerations, and

external confirmation. Each technique was used to gather corroborating evidence that when analyzed would allow the audit team to reach certain conclusions relating to contractual compliance; conformance to industry practices; appropriate documentation of policies and procedures; appropriately documented expenses, a control environment with the appropriate oversight, monitoring, reporting, delegation of authority, and transparency that would be expected of a government sponsored health plan.

In addition to the site visits and interviews, the engagement team analyzed submitted materials. We evaluated policies and procedures, Kentucky Administrative Regulations, the contract between DMS and UHC, information received by the Department, contract monitoring reports, industry related compendia, sought information from provider industry association groups, analyzed applicable federal regulations, held a meeting with the Kentucky Department of Insurance, discussed the capitation rate range development process with the Department's actuary, and held discussions with other state Medicaid programs and health plans regarding industry practices.

Following the on-site activities, DMS, PHP, and MSLC held numerous telephone meetings, intensive document review (IDR) sessions, and interviews in an effort to address missing and incomplete data (i.e., from prior requests), to request new information (i.e., first-time requests) when necessary, and to resolve data issues. Although the health plan continued to make an effort to identify missing or incomplete data and documentation in response to the audit requests, approximately one-third of the requested materials from UHC, AMHP, subcontractors, and vendors were never submitted. Health plan staff informed DMS and Myers and Stauffer that certain historic materials could not be located, or perhaps did not exist. Nearly all of the missing or incomplete information was related to subcontractors or vendors, or policy documents from the earlier portions of audit window (i.e., circa 2008 – 2009).

Data Collection from Sponsoring Organizations

Data collected from sponsoring organizations was used to confirm information obtained during interviews, and to corroborate data submitted by UHC and AMHP. Requests were sent to sponsoring organizations on October 21, 2011.

While not specifically a "sponsoring organization," an open records request was submitted to the UofL Medical School on December 12, 2011, because of the school's placement of key personnel within the health plan and the school's proportionate representation on the UHC Board of Directors. The table below provides an overview of the responses received.

Sponsoring Organization	Status
Jewish Hospital and St. Mary's Health System	The requested information was timely submitted.
Louisville-Jefferson County Primary Care Association	Held meeting with Mr. Ed Schoenbaechler, an attorney representing the organization. Mr. Schoenbaechler described that each member of the association is individually a sponsoring organization, and that payment data is specific to the facility. Therefore, we prepared additional questions and sent them to Mr. Schoenbaechler and requested that he submit the questions to each member facility. The requested due date for responses was February 1, 2012. A follow-up was sent to Mr. Schoenbaechler on February 7, 2012. We were informed by Mr. Schoenbaechler that he would follow-up on the requested information. We received responses to questions from Family Health Center, and Park DuValle Health Center.
Norton Hospital	Attorney representing Norton Hospital, Janet Jakubowicz responded on December 19, 2011 by indicating "Norton does not have any documents responsive to your requests…" Michael Gough, CFO of Norton Hospital, provided information during a previously scheduled interview on January 20, 2012. Although the purpose of the interview was related to his participation on the UHC Board of Directors, Mr. Gough was agreeable to answer questions pertaining to the sponsoring organization request. The information he provided contradicted the response received from Ms. Jakubowicz. Based on Mr. Gough's response, we considered Norton Hospital to be responsive to the request.
University of Louisville Medical School	Open records request was processed and the responses were timely submitted.
University Medical Center	The requested information was timely submitted.
University Physician Associates	Information was untimely submitted but received in April 2012.

Gaining an Understanding of Data and Documentation

In January 2012, we scheduled numerous Intensive Document Review (IDR) sessions with UHC personnel. During these sessions, we collaboratively reviewed with PHP

documentation they had submitted. Additionally, we conducted question and answer sessions regarding specific subjects or programs. IDR sessions were held with UHC personnel on January 11, January 17, January 24, and January 25. Though time intensive, these sessions proved to be very valuable.

Numerous source interviews and/or meetings were completed as listed in the table below.

Name	Date	Mode	Position/Title
Shannon Turner	10/24/2011	In Person	Former Passport Employee
Bob Barbier	11/3/2011	Telephone	University Medical Center
Janet Jakubowicz	11/4/2011	Telephone	Attorney representing Norton Hospital
David Stanley and Loree Ching	1/11/2012 1/24/2012	In Person	UHC Chief Financial Officer; UHC Interim Chief Compliance Officer
Mark Carter	1/17/2012 1/18/2012 1/24/2012 1/25/2012	In Person	UHC Chief Executive Officer
Nicole Gaines	1/17/2012	In Person	Former Passport Employee
Michael Mitchell and Ralph Hall	1/18/2012	In Person	University of Louisville Physicians
Terry Gossum and Glenn Bossmeyer	1/18/2012	In Person	Former Employee of UofL; In-house Counsel for UofL
Michael Gough	1/20/2012	Telephone	Norton Hospital
James Taylor	1/23/2012	Telephone	University Medical Center
Edward Schoenbaechler	1/23/2012	Telephone	Attorney representing Louisville-Jefferson County Primary Care Association
Bill Wagner	1/24/2012	In Person	Family Health Center and Chairman of the UHC Board of Directors
Larry Cook, MD	1/24/2012	In Person	Former Chairman of the UHC Board of Directors
Gregory Postel, MD	1/27/2012	Telephone	PHP Board Member

Name	Date	Mode	Position/Title
John Morse	1/31/2012	Telephone	UofL Primary Care Center
Steven Eisenberg	2/9/2012	Telephone	Attorney representing University Physicians Associates
Anthony Lampasona	2/9/2012	Telephone	Landmark Healthcare Properties Fund LLC

Myers and Stauffer attended the UHC Board of Directors meeting on January 11, 2012, prior to the vote to enter Executive Session, at which point the meeting was closed to the public. Additionally, we attended the UHC Partnership Council meeting on January 17, 2012. In both situations, our attendance was for observation purposes only. We requested and received materials that were presented at both sessions.

Potential Public Interest Issues

As part of the initial meeting with the Department and Secretary Miller, Myers and Stauffer received copies of correspondence the Department and/or the Secretary had received in the months preceding the audit. The subjects described in those materials were henceforth referred to as “public interest issues”, for purposes of this engagement.

To understand the validity and veracity of these potential issues, a supplemental data request was prepared and sent to Passport on January 18, 2012. We requested that they respond to each question or issue that was raised in the correspondence. We further requested that they coordinate with other parties or organizations as was necessary to provide an expeditious and thorough response.

PHP CEO Mark Carter attempted to schedule a meeting on January 25, 2012 to include members of the UofL faculty physicians, the UofL medical school, sponsoring organizations, and/or the UHC Board of Directors to facilitate discussion of the issues and to prepare a comprehensive and coordinated response. Mr. Carter subsequently informed us that he was unable to achieve full participation; therefore, the meeting was not scheduled.

Despite being unable to facilitate a collaborative response to the issues, we solicited responses for our questions from sources that we considered to be the most likely to hold the information that was needed. Responses were due on February 1, 2012. Responses were received from UHC (January 24, 2012); Family Health Center (January 24, 2012); and the UofL School of Medicine (February 6, 2012 and February 8, 2012). Information was submitted by UPA on April 4, 2012.

LIMITATIONS AND ASSUMPTIONS

This section describes the assumptions and/ or limitations that should be considered when reading the analysis, discussion, and findings included in this report.

1) Passport Health Plan has completed a substantial transformation of their business model as a result of the changes required from the Governor's Corrective Action Plan and from contractual changes required by DMS. PHP has also implemented a number of self-initiated changes to further improve the operational and administrative functions within their plan. Readers of this report should be mindful that the audit window (i.e., period addressed by this engagement) was July 1, 2008 through June 30, 2011, a time when the Passport Health Plan was considerably different than the way it operates today.

2) There have been numerous environmental factors that have had an impact on the analytical activities required by this engagement. These factors include, but are not limited to the following:

   a. Availability of information, missing or incomplete information

   b. The Passport business model during the period under examination relied on numerous contributing entities and shared responsibilities that created an environment where there were undocumented procedures, unclear lines of authority, related party issues, and conflicts of interest, among other issues

   c. Delayed receipt of materials and responses

   d. In response to certain requests for information, we were referred to another entity, only to be referred back to the first entity when we requested it from the second

   e. Health plan administrative staff did not maintain certain records during the audit window that could be located and made available within a reasonable time period

   f. Certain management personnel did not have an accurate understanding of the definition of "subcontractor" and "vendor" as those terms were used during the audit window

   g. Certain information we received contained redactions, or was not submitted for "proprietary" reasons. Certain responses were labeled "under attorney review". Certain forms we requested were not completed (e.g., columns on forms hidden or not answered). Many of the contracts that were submitted were the unexecuted versions.

h. The health plan, its Board of Directors, and stakeholders operate in a highly political environment

3) Unless otherwise specified, we did not independently validate information submitted from UHC, AMHP or PHP subcontractors and vendors.

4) While other provider-sponsored organizations exist in the Medicaid environment across the country, the Passport Health Plan model during the period of the examination appeared to be one of the most unique models in the country, based on factors such as: the limited lines of business, the integration of numerous hospital systems and provider groups, the sole-source contracting authority, the heavy reliance on subcontractors and their placement in key managerial functions within the plan. Readers should consider the unique features of the Passport model when compared to other Medicaid managed care models. The changes made to the Passport business model effective July 1, 2011 make it more similar to other Medicaid provider sponsored plans.

5) Although requested, a business plan applicable to the audit window was not available from UHC or AMHP. Management personnel indicated that all of the essential functions that would be common to a business plan were completed by health plan management or by the Board of Directors. However, the health plan did not have a formalized written document. The absence of a formalized business plan limited the utility of certain analysis completed for this engagement.

6) Passport was unable to provide the methodology used to prepare the medical loss ratio (MLR) spreadsheet, nor the process used to allocate shared administrative costs across its various lines of business during the audit window. The absence of this information limited the ability to confirm the accuracy of their reported MLR.

7) Because we were unable to reach an agreement regarding the set of entities that met the definition of a subcontractor as defined in the contract between DMS and PHP, we received limited information that was requested from subcontracted entities.

8) We requested copies of detailed accounting policies, processes and procedures related to the methodology utilized by Passport for allocating costs across lines of business during the audit window. We received limited information in response to this request, which limited the utility of the analysis anticipated for this engagement.

9) We requested clarification from AMHP regarding whether AMHP utilizes a cost allocation plan for use in developing the health plan capitation (a “per member/per month” or “pmpm”) rate ranges. We requested that AMHP describe the methodology used for allocating costs for corporate based employees and “back office fees” (i.e., for employees who are not full time

dedicated to a particular plan). We also asked that AMHP address how cost allocations utilize project and non-project specific time collection, expenses, administration, facility costs, services, and overhead, including same for related parties and parent company costs. Finally, we requested that if a cost allocation plan has been used to compute Passport related costs, AMHP submit the cost allocation plan that was in effect as of June 30, 2011. Although AMHP submitted a two page document entitled "AmeriHealth Mercy Health Plan Cost Allocation Methodology", included in Exhibit E, this document does not appear to address the request for the methodology applicable to Passport's financial reporting. The absence of this information limited the utility of the analysis anticipated for this engagement.

10) The baseline data request included a request for certain documents relative to the timeliness of claims payments, and related documents for the audit window. While we received a response from AMHP, we did not receive information from any of the other subcontractors responsible for adjudicating claims, which would likely include Block Vision, PerformRx (i.e., their subcontractor), AmeriHealth HMO, MCNA, etc. Therefore, we are unable to fully analyze the timeliness of claims payments during the period July 1, 2008 through June 30, 2011 for subcontractors other than AMHP.

11) Passport submitted documentation regarding a potential "Re-Design" of the Provider Recognition Program in 2012. We are not aware of the current status of the Re-Design efforts and DMS has indicated that they have not received for review the "Re-Design" of the Provider Recognition. Based on a review of the re-design materials submitted by the health plan, it appears that substantial changes to the program are being considered for 2012.

Analysis and Discussion

OBJECTIVE 1A: PASSPORT BUSINESS PLANS

The key activities related to this task include:

Examine Passport's and AmeriHealth Mercy's business plans including the following areas:

- Development
- Implementation
- Tracking
- Modification

The analysis of Passport and AmeriHealth Mercy (AHMP) business plans was completed by reviewing the current contract between DMS and PHP, and interviewing key staff. For this activity, we also reviewed the original contract. We worked with the Department to understand the Department's process to obtain, approve, and monitor changes to the business plans and the requirements DMS includes in the contract between DMS and UHC.

Business Plan

A comprehensive business plan is the blueprint by which a health insurance plan will build, operate and manage its day-to-day functions and will ensure compliance with regulatory and contractual obligations. The business plan outlines the objectives of the health plan at inception and is modified as appropriate as the health plan matures. A well-prepared business plan will include such items as the creation and ownership of the health plan, identification of business partners or subcontractors, a responsibility matrix, a description of the health plan's mission, a narrative description of the services provided, and the populations and markets that the health plan will serve. A business plan will also include high level strategies for implementation, marketing, pricing, sales, management and personnel. Finally, a business plan may include, but not be limited to comprehensive financial planning including forecasting of revenues and expenses, a breakeven analysis, key financial ratios, assessments of creditworthiness and other financial characteristics.

It is important to note that although the contract between DMS and Passport references a business plan (budget) that is financial in nature, DMS provided guidance to Myers and Stauffer regarding the components of a business plan that would satisfy their contractual requirements. We understand that DMS anticipates further communication with Passport on this subject.

Myers and Stauffer requested the business plan for UHC on September 2, 2011. Although PHP provided a number of financial planning documents, and AmeriHealth Mercy (AMHP) provided a spreadsheet related to the transition of duties from AMHP to

PHP, a robust business plan (i.e., other than financial reports) was not available. Following discussion with DMS and PHP regarding this issue, PHP provided the following comments.

> *Based on our discussion with DMS and Myers and Stauffer auditors about the business plan comments in the DMS audit report, we plan [to] prepare future business plans that will include the following elements:*
>
> - *Business Plan Executive Summary*
> - *Market Analysis*
> - *Company Description*
> - *Organization & Management*
> - *Marketing & Sales Management*
> - *Service or Product Line*
> - *Funding Request*
> - *Financial Projections*
> - *Appendix*
>
> *Generally, management has considered all of the above elements in the development of its previous budgets. However, these elements were not included in a single document labeled as a business plan.*

We conducted the following activities in order to attempt to gain an understanding of the PHP business model:

- Interviews with key management and operational staff at both Passport and AMHP
- Analysis of financial data provided by Passport and AMHP
- Interviews with executives, health plan personnel, and former health plan personnel, including the Executive Vice President of Health Affairs at UofL and the Associate Vice President from UPA
- Consideration of UHC Board of Director's Mission Statement, Organizational Values and other related documents
- Review of the Passport public website
- Discussion with Passport management and review of Power Point presentation (See Exhibit B) detailing the health plan structure
- Review of supporting documentation submitted to CMS for the initial and subsequent amendments to the Section 1115 waiver

- Review of policies and procedures from both Passport and AMHP

During the audit window, UHC operations included a fully integrated third-party administrator (TPA), AmeriHealth Mercy Health Plan (AMHP) who served in key management and executive positions. The TPA also provided nearly all other administrative and operational functions of the health plan. AMHP employed a large number of staff who was physically located in Louisville, Kentucky, with additional support provided at the AMHP corporate office location in Philadelphia, Pennsylvania. The Executive Director and Chief Financial Officer of Passport Health Plan were employees of AMHP. UHC had approximately six staff members, all of whom were leased from other entities such as UofL or UPA.

We interviewed a number of individuals at PHP and AMHP, both current and former employees. For purposes of this discussion, an "employee" included individuals who provided services to PHP under a leasing arrangement. We also requested documents which could provide insight into the creation, development and on-going operations of the health plan. Essential to this request was the policies and procedures used to conduct the daily operations of the health plan. PHP provided few written policies and procedures that were applicable to the audit window. Many of the documents provided were newly drafted in 2011 by the current executive leadership. PHP personnel indicated that because of the relationship with AMHP during the examination period, Passport operations were conducted based on AMHP policies and procedures.

As stated earlier in this report, Passport has experienced a number of significant changes in recent years. In late 2010, in response to a corrective action plan issued by the Governor, the Board of Directors of UHC released the management team in place at UHC/PHP and began the process of rebuilding its management team, including the composition of its Board of Directors. On July 1, 2011, staff located in Louisville and assigned to Passport who had previously been employed by AMHP was hired as employees of UHC. In addition, a transition plan was developed to outline the transition of administrative and operational responsibilities from AMHP to Passport. This transition began on July 1, 2011. The development of UHC specific policies and procedures has been a significant undertaking by UHC management, which included a comprehensive set of policies and procedures to meet the goals of the transition as well as the on-going operations. Finally, since June 30, 2011, we were informed that Passport eliminated the Medicare Advantage plan and has expanded other services. DMS confirmed the Medicare line of business was terminated on December 31, 2011.

The absence of a well-defined business plan as defined by DMS for purposes of this report could have contributed to the following operational and internal control weaknesses within the Passport business model *during the audit window*:

- Unclear lines of authority

- Unclear contractor/vendor responsibilities

- Unknown/unclear list of subcontractors and vendors. We requested a list of all subcontractors and vendors and participated in several meetings with PHP in an effort to assist them in responding to the request. We received multiple lists from PHP. Certain PHP personnel did not have an accurate understanding of the distinction between a "subcontractor" and a "vendor" or that the lists accurately reflect the designations of these entities based on the definition included in the contract between DMS and UHC.

- Insufficient vetting process to eliminate transactions with excluded providers. When we inquired about this procedure, PHP provided the following response.

  > *"Excluded providers are placed on a non-payment agreement within the claims system to prevent payment of any claims from these providers."*

- No clear methodology to identify and mitigate issues and concerns from related party transactions.

It is important to note that DMS added the following language to the SFY 2012 contract between DMS and PHP regarding the submission of a business plan.

> *Section 16.21 Disclosure of Certain Financial Information. The Contractor agrees to provide its annual business plan (budget) to the Department within 45 days of the contract execution. The annual business plan furnished to the Department shall include a schedule setting forth the salaries, incentive compensation and benefit costs associated with the following Executive Management personnel: Chief Executive Officer, Chief Financial Officer, Chief Compliance Officer, Chief Medical Director, Vice President, Clinical Operations, Vice President, Operations, Vice President Public Affairs and Vice President, Information Technology. The business plan will include a comparison of such expenses to recognized industry surveys or benchmarks. The annual business plan submitted to the Department will also include a schedule setting forth planned expenditures for grants, sponsorships, donations, insurance, and medical costs.*

Contract between DMS and UHC/PHP

Myers and Stauffer was provided with copies of the contract and amendments applicable to the audit window. We compared terms in the amendments to those in the base contract. The complete contract comparison is included in Exhibit A of this report. Although DMS has substantial oversight of Passport, there was an opportunity to improve the contractual requirements for developing and maintaining a business plan. DMS added section 16.21, above, to the SFY2012 contract to reinforce the requirements of the business plan.

Observations, Findings or Recommendations Related to Passport Business Plans

1) The absence of a formal business plan during the audit window left the health plan vulnerable to be operated as the management in place deemed appropriate. Health plan administration and operations were not adequately documented during the audit window. During that period, there were few, if any policies and procedures in place specific to Passport Health Plan that would have guided and provided boundaries and limitations necessary for the appropriate management of the plan. PHP has indicated that they intend to address the lack of a formal business plan in the future. Additionally, the health plan has developed administrative and operational policies and procedures, subsequent to the audit window.

2) During the audit window, there were no specific provisions described in the contract between DMS and UHC for UHC to submit a comprehensive business plan. There were no specific requirements that UHC request DMS' authorization or approval of changes to the business plan. DMS addressed this observation by establishing requirements for the 2012 contract.

3) By placing AMHP employees in high level positions of authority, including Executive Director of Passport Health Plan and Chief Financial Officer of Passport Health Plan, there was insufficient monitoring of the TPA and other benefit subcontractors during the period covered by the audit. Because certain subcontractors of PHP are related parties of AMHP, there was significant risk of conflicts of interest or independence of those individuals (i.e., AMHP employees) who performed those functions prior to July 1, 2011.

4) During discussions with Passport employees who were AMHP employees prior to July 1, 2011, it was apparent that there was a significant amount of confusion regarding the roles and responsibilities related to the oversight of Passport's daily operations.

5) During the course of conducting interviews, we were informed that, during the period of our examination, a significant amount of uncertainty was present in the relationship between UHC/PHP and AMHP. This may have been as a result of discussions related to proposed rate reductions to the AMHP contract and/or modification to the methodology for calculating incentives paid to AMHP for cost savings initiatives.

6) In spite of contract provisions requiring that the Board of Directors have control over all policies and assets of Passport, interviews with former UHC staff revealed that they did not have direct access to the financial systems or to the bank accounts for the health plan during the period of the examination. PHP

informed us that the new TPA agreement with AMHP contains service level agreements which include certain performance standards, appropriate oversight of TPA functions, and that assets of Passport are under the exclusive authority of UHC.

Objective 1B: Comparison of Health Plan Operations and Best Practices

The key activities related to this task include:

A comparison of operations with other Medicaid managed care health plans and identification of best practices.

a. Utilization of benchmarks against which to compare Passport's operations against other similar and comparable managed care health plans adjusting, if necessary, to take into consideration Passport's sole source managed care health plan status.

b. Examination of the consistency of Passport's policies regarding expenditures and cash distributions with other managed care health plans.

In order to identify best practices of other Medicaid managed care health plans and perform a comparison of 10 operational characteristics selected by DMS, we identified, for DMS approval, approximately five Medicaid health plans and attempted to obtain data and information from those health plans via a survey document. Travel and expenses from Passport were compared to other state Medicaid health plans and we examined the consistency of Passport's policies regarding expenditures and cash distributions to those of the other Medicaid managed care health plans. Based on the information available, we attempted to identify and make recommendations regarding any operational performance gaps noted.

The first step in this task was to identify the states and health plans which Myers and Stauffer would approach to participate in the survey. We attempted to choose states and/or health plans that would have comparable attributes to Passport. Once the states were identified, the survey tool was developed and approved by the Department.

The purpose of the survey was to identify policies, procedures and other metrics from the areas of greatest concern such as the health plan's ownership, governance, and operations. The survey tool was designed to collect information for the State Fiscal Year (SFY) 2011 (July 1, 2010 through June 30, 2011), unless otherwise specified. An executive or a designated employee with knowledge of the entire health plan was asked to complete the survey. A time limit of 14 days was established for each plan to complete the survey and return to Myers and Stauffer.

Each applicable state Medicaid agency was contacted to obtain permission to communicate with the selected Medicaid managed care health plan and to request that agency's assistance in encouraging the Medicaid managed care health plan's

cooperation. Each health plan's participation in completing the survey was, however, voluntary and as a result, the response rate was somewhat limited.

Although the rate of response to the survey was not as high as was desired, we were able to identify certain comparable items relative to Passport and the business model under which it was operating during the period of the examination. A description of each section of the survey follows, along with the relative observations or findings.

Survey Section One

Section one of the survey addressed basic plan characteristics, such as legal name, type of corporation, corporate governance, lines of business, enrollment numbers, and number of employees.

- We noted that nearly all of Passport's functional areas that served multiple contracts and/or lines of business (e.g., claims adjudication, credentialing, nurse line, etc.), were the responsibility of AmeriHealth Mercy during the time period being examined, although some functions were performed in the local office. The majority of these functions have been transitioned to Passport under an ongoing plan with the exception of the Fraud, Waste and Abuse, which Passport has contracted with the company, TC3, to perform.

- We noted that, during the examination period, Passport did not indicate an internal audit functional area nor was internal auditing included in any other functional area. PHP indicated they are now performing internal auditing and have hired a Director of Internal Audit.

  - We requested information regarding Passport's internal audit function and received the following response:

    > Passport did not have an internal audit function during the audit window.

  - We also asked for clarification regarding Passport's response to the question which asked if the health plan corporate structure included any ownership of any health care service provider. The following response was received:

    > We interpreted B1.28 to ask if Passport Health Plan owns any provider organizations or offices or owns any subcontractors or vendors. Based on that interpretation, we answered No…

Survey Section Two

The largest section of the survey, section two – Local Health Plan Business Characteristics, includes questions regarding the plan's standing or status with accreditation bodies, number of employees and functions performed at the local health

plan, and subcontractor and/or vendor functions. This part of the survey was designed to describe the business model structure and identify risk areas within the health care operations.

In reviewing the responses submitted by Passport to the survey questions included in section two, we noted the following:

- PHP's responses in certain instances were reflective of the current operations of the health plan versus the time period which was being examined.
- In response to question B2.15, which asks about the number of employees who serve the local health plan and are also located at the local health plan, Passport indicated the number of leased and contracted employees prior to the July 1, 2011 transition of AmeriHealth Mercy employees, located in the Louisville office, who subsequently may have become Passport employees.
- Question B2.21 asks for the location of the Financial Management functions. Passport indicated this function is performed at the local health plan office; however, based on the interviews conducted with Passport and AmeriHealth Mercy, the Financial Management function is primarily performed in the AmeriHealth Mercy office in Philadelphia, Pennsylvania. PHP provided the following clarification:

  > During the audit period, all financial functions were performed by AMHP staff. Functions performed in Philadelphia included general accounting, accounts payable, revenue reconciliation, cash management, and payroll. Functions performed in Louisville included budgeting, financial forecasting, internal and external reporting, ad hoc financial analysis, and liaison with Kentucky Department of Insurance.

- The responses given by Passport to questions B2.22 and B2.42, Performance of Grievance and Appeals, are conflicting. In B2.22, Passport indicated the grievance and appeals function is performed at the local health plan office; however, in question B2.42, Passport responded that a subcontractor or vendor performs grievances and appeals functions. It appears the latter response may be correct. PHP provided the following clarification:

  > Which company handles member appeals? PHP
  > Which company handles member grievances? PHP
  > Which company handles provider appeals? PHP
  > Which company handles provider grievances? PHP
  >
  > When a subcontractor is involved we would use the subcontractor's staff to help us with the investigation and resolution of the grievance or appeal. If a pharmacy claim can be approved, the claim is approved by PerformRx staff. If it is possible that the

pharmacy claim may not be approved, it is sent to PHP for review by PHP staff.

- A similar situation as described above appears to have occurred with questions B2.24 and B2.43, related to Medical/ Utilization Management. Passport responded to question B2.24 indicating this function is performed at the local health plan office; however, in question B2.43, Passport indicated that a subcontractor or vendor performs the function. It appears the latter response is correct. PHP provided the following clarification:

  Medical/Utilization Management activities, including pre-authorization, concurrent review, retro review, case management, care management, disease management and condition management programs are all handled by local staff (PHP associates) either in the health plan office or onsite at the provider's office/facility. Utilization management for dental, vision and pharmacy services is performed by subcontractors. All activities of subcontractors are monitored through our delegation oversight development and coordinated through the appropriate PHP operational units.

  Subcontractors in the areas of vision, dental and pharmacy benefits provide investigation and preparation work when it pertains to their services. Subcontractor's processes are reviewed and oversight is applied as per NCQA requirements for delegated entities. Local PHP Health Plan staff attends every state hearing, even those for subcontractor services.

  Yes, in the areas of vision, dental and pharmacy. Block Vision handles vision, MCNA handles dental and PerformRx handles pharmacy services.

- Passport indicated that the Member Services, Quality Assurance, Compliance, Process Improvement, Project Management, and Human Resources functions are all performed at the local health plan office. Based on documentation and interviews conducted, we understand that these functions were the responsibility of AmeriHealth Mercy employees who were located at the local Louisville office during the period being examined and that these functions are now being performed by PHP employees.
- Passport indicated there were subcontractors and vendors who are required to perform fraud and abuse detection; however, no subcontractors or vendors are listed in the response.
  - A request for a completed response regarding subcontractors and vendors who are required to perform fraud and abuse detection was sent to Passport, who responded as follows:

AmeriHealth Mercy Health Plan, Block Vision, Inc., MCNA of Kentucky, LLC, SironaHealth, PerformRx, AmeriHealth HMO, University Physicians Associates

Survey Section Three

The third section of the survey, Health Plan Contractual Characteristics, relates to the health plan contract with the state Medicaid agency and specific contractual provisions related to travel expenses, marketing and advertising, lobbying and political activities, employee compensation, bonuses, and other monetary items. The purpose of this section of the survey is to identify financial risk and areas requiring further analyses, if noted.

In reviewing the responses submitted by Passport to the questions included in section three of the survey, we noted the following:

- Passport indicated they do not subcontract with or use as a vendor any subsidiaries or related corporate entities. Based on our understanding, however, AmeriHealth Mercy and PerformRx, both UHC contractors, could be considered related parties as PerformRx is a subsidiary of AmeriHealth Mercy. Also, University Physician Associates (UPA), which has been contracted to perform credentialing services for Passport, albeit at no cost, could be considered a related party as it is associated with University of Louisville Medical Center, a sponsor of University Health Care, Inc. dba Passport Health Plan.

- A spreadsheet of travel and related expenses was received in response to the question relating to the total travel and related expenses for SFY 2011.

- One question requested the total marketing and advertising expenses for a 12 month period. Passport responded by providing copies of invoices for marketing and advertising for the analyzed period, January 1, 2008 through June 30, 2011.

- For the question regarding the use of any limitations or restrictions on executive level compensation, Passport indicated a response of “No”. We have since received a document which indicates such limits and restrictions on executive compensation. UHC now utilizes an outside consultant to evaluate executive compensation, as well as a Board-level executive compensation committee.

Survey Section Four

Section four of the survey relates to the Ancillary Provider and Member Characteristics of the health plan. This section of the survey sought responses related to the number of and changes in health care service providers, as well as, the degree of satisfaction of health plan members and providers by the number of grievance and appeals by each group.

- The net decrease in physician groups enrolled for Passport for the examination period is approximately four percent, which is comparable to another health plan's net change of approximately three percent. Passport reported dis-enrolling 490 pharmacies in the survey period. The explanation indicates PerformRx initiated the dis-enrollments as a result of a review of pharmacy credentials and failure (by the pharmacy) to show evidence of valid credentials.

  We asked Passport to provide more information regarding the disenrollment of the 490 pharmacies including any information regarding the notification to DMS regarding this situation. The following response was received from Passport:

  > The two most common reasons that the number of network pharmacies decreased from 2010 to 2011 are as follows: 1. Loss of group affiliation/contract – many independent pharmacies contract through intermediary pharmacy groups. The pharmacy groups contract with PerformRx. When the pharmacy changes/loses its group affiliation then it technically [is] not eligible to be counted as a PerformRx network pharmacy. PerformRx identified this as a gap during our PBM accreditation process with URAC, and removed many pharmacies from its network in 2010 as a result. 2. Pharmacy Credentials Expire- PerformRx provides pharmacies with an opportunity to submit their credentials. Pharmacies that do not respond to our notifications are removed from the network. We have found that pharmacies who have low utilization with a given health plan are less responsive to credentialing efforts than pharmacies with high utilization.

- The survey asked for the number of emergency department visits per 1,000 members. The response from Passport indicates a low utilization rate. Traditionally, Medicaid beneficiaries are above average consumers of emergency room services. Myers and Stauffer did not receive the detail calculation information to validate the accuracy of this response. After discussion, PHP provided the following additional information regarding their response:

  > We believe the total rate of 66.1 visits/1000 relates to ED utilization in member months. The metric of ED visits/1000 member months is consistent with the manner in which HEDIS measures and reports ED utilization. When using the HEDIS measurement, the ED utilization is higher in relation to the HEDIS Quality Compass(tm). 2010 HEDIS results show the Plans' ED utilization to be 70.2 visits/1000 member months. The area of ED utilization remains of interest to PHP as efforts to decrease unnecessary medical expenses and improved health outcomes and quality are ongoing. New initiatives are underway to help decrease unnecessary ED utilization.

Survey Section Five

This section of the survey asks for financial measurements which can be used to understand the financial state of a health plan. Myers and Stauffer did not receive detail information to independently calculate the measures in this section of the survey. Comparative data was not available in all instances.

In reviewing the Passport responses to section five, we noted the following:

- The per member per month (PMPM) medical expense is the calculation of total medical expenses in a month divided by the total number of members enrolled in the plan in the measurement month. Passport reported $374.40 per member per month medical expense for State Fiscal Year (SFY) 2011.

- The PMPM hospital and pharmacy expenses are a subset of the PMPM Medical Expense reported in response to the question above. For PMPM Hospital and Pharmacy expenses, Passport reported $136.93 and $56.98, respectively.

- For the PMPM Total Services Expense, PMPM Revenue, and the PMPM Net Income, Passport reported $398.31, $390.91, and ($2.56), respectively, for SFY 2011.

- The current ratio is an indication of a plan's solvency, or its ability to meet its short term obligations, i.e., the dollars of current assets available to cover each dollar of current debt. Generally, the higher the current ratio, the greater the ability of a health plan to meet current obligations as they become due. A current ratio of one or greater is typically the goal of any entity. The current ratio is calculated by dividing the current assets by the current liabilities. Passport reported a current ratio of 1.77.

- We requested the days cash on hand, which indicates the number of days the plan could cover operating expenses with its current available cash. The greater the number of days cash on hand, the less effect temporary fluctuations in the plan's revenue stream have on the daily operations of the plan, and the greater the plan's ability to meet its short-term obligations in times of revenue uncertainty. Passport reported 65.84 days of cash on hand.

- Passport reported 2.4 as the ratio of cash-to-claims payable, which is an indication of a plan's ability to pay off claims payable with available cash and short-term investments. Lower ratios may indicate that a plan is experiencing cash shortages or deliberately delaying payments. Ratios less than 1.00 indicate reliance on other current assets such as accounts receivable to meet claims.

- We requested the number of days in claims payable, which measures the average length of time in days that claims are outstanding. In other words, this is the number of days of claims a plan owes its claimants. If a plan's average length of time in which claims are outstanding is greater than the industry

average, the plan may be disputing claims or deliberately delaying payments. Passport reported 29.2 days in claims payable. It was also noted that the contract between DMS and Passport requires a prompt adjudication of the claims submitted in 30 days or less.

- The Medicaid profit margin is the amount of net income generated by a dollar of Medicaid revenues. Competition, capital structure, and operating characteristics cause the margin to vary within and among industries. The profit may also vary between not-for-profit and for-profit organizations. A negative Medicaid profit margin means an operating loss has occurred in the period being measured for services provided to this population. Passport reported ($.66) Medicaid profit margin, which indicates a loss for the health plan for SFY 2011.

- The medical loss ratio (MLR) shows the percentage of total Medicaid premium revenue that covers expenses classified as medical and hospital expenses by the plan. For SFY 2011, Passport reported an MLR of 95.78 percent. As the percentage grows closer to 100 percent, the plan could be at risk. An MLR in the middle 80 percent range is a common range for a health plan. PHP management informed us that they attempt to operate the health plan with minimal administrative costs. The DOI conducted procedures at the health plan and in its February 2011 draft report no concerns were noted regarding the financial stability of the health plan. In addition, PHP provided the following:

  > For the time period July 2010 thru June 2011, PHP's medical loss ratio for its Medicaid business was 95.78%, calculated as $799,189,626 of revenue and $765,434,467 of medical costs. During the audit period, only two subcontractors separately identified administrative fees (PerformRx and Sirona Health) and both were included in Medical Costs.
  >
  > We plan to further investigate this particular metric to insure that our reported MLR is consistent with NAIC requirements and/or industry practice. At the present time, we have no reason to believe a change would have a material impact on PHP's MLR.

√ Observations, Findings or Recommendations Related to Comparison of Health Plan Operations and Best Practices

1) Internal Auditing does not appear to be listed in the functional area documentation submitted by Passport. Fraud, waste, and abuse activities are listed as an AmeriHealth Mercy's responsibility. PHP indicated they are now performing internal auditing and have hired a Director of Internal Audit.

2) The survey requests information regarding any health care service providers which may be owned by or affiliated with the owners of the health plan. Passport indicated their response to be No; however, a review of additional information provided by Passport provides an indication that several of the health plan sponsors are also health care providers.

3) There were conflicting responses given in section two of the survey regarding responsibility of functional areas. PHP has attempted to clarify these conflicts when possible.

4) Passport indicated that they do not subcontract with or use vendors who are subsidiaries or corporate related entities. It appears that this response may be inaccurate or Passport may have misunderstood the question.

5) Passport reported low utilization rates for emergency department visits per 1,000 members. PHP clarified that their response was indicative of the HEDIS measure.

Objective 1C: Revenue, Compensation, and Expenditures

The key activities related to this task include:

Examine how Passport and its subcontractors, including non-benefit subcontractors, utilize funding received from the Cabinet to provide medical services to Region 3 members.

a. Perform detailed analyses of administrative and medical services expenditures to specifically identify fraud, waste or abuse of Medicaid funds.

    i. Evaluate the methodology to establish salaries, bonuses and other payments to Passport or AmeriHealth Mercy Health Plan (AMHP) employees and contractors.

    ii. Assess whether the criteria for establishing salaries, bonuses and other employee/contract payments are reasonable, allowable and applied equitably throughout the organizations.

b. Perform analyses to determine whether the following types of expenditures are reasonable, necessary and allowable:

    i. Legal fees and expenses;

    ii. Auditing, actuarial and other consulting expense, including consulting by University of Louisville employees;

    iii. Travel/Meals;

    iv. Marketing/Advertising;

    v. Outsourced services;

    vi. Boards, Bureaus, and Association fees;

    vii. Collection and Bank Services fees; and,

    viii. Other expenses not compatible with Passport's non-profit status.

c. Perform analysis of the expenditures listed in above Section to determine the services received as a result of the expenditure and how the services were utilized within Passport operations.

d. Identify any excess profits resulting from Medicaid operations of Passport.

The above tasks were achieved by reviewing documentation submitted by Passport and its subcontractors and by interviewing current and former staff members.

Analysis of Passport Financial Management Policies and Procedures

Interviews with Passport staff revealed that a limited number of Passport-specific financial management policies and procedures were in effect prior to July 2, 2011. Staff performing those functions prior to July 1, 2011 utilized AMHP policies unless a specific policy for Passport had been developed. Since that time, Passport has undertaken the task of developing and implementing its own internal financial management policies and procedures. Passport informed us that they are continuing this process. In reviewing the newly developed policies that Passport provided, we noted that Passport appears to be taking care to address issues and concerns that have arisen in prior years related to travel and expense reimbursement.

We were not provided any policy and procedure documents specific to the financial management and reporting functions and we are therefore unable to comment regarding the adequacy of those, if they exist.

Interviews with Passport indicated there currently are formal quality assurance processes related to financial management or reporting. AMHP provided copies of their written quality assurances processes as they relate to financial management.

Analysis of Medical Loss Ratios

The MLR is the relationship (stated as a percentage) of medical expenses incurred on behalf of a health plan's members to the amount of premium revenue earned. The MLR is used in the health plan industry to measure profitability, efficiency, and viability of specific lines of business within a health plan. MLR's approaching 100 percent are a potential indication of fiscal distress in a line of business or health plan. Although PHP has reported a $1.5M loss for CY 2011, the DOI has not indicated concerns regarding the health plan's financial operations in its draft report for 2011.

As part of this objective, the calculation of Passport's MLR was analyzed in order to ensure the calculation was being performed accurately and consistently and to identify any unusual trends or concerns. The MLR is a calculated by using the formula below:

$$\frac{\text{Total Medical Expenses}}{\text{Enrollment Revenue}} \times 100 = \text{MLR percentage}$$

In addition to the MLR, another calculation required is an estimate of the medical expenses incurred but not yet received by the plan in the form of a claim, which is usually referred to as the Incurred But Not Reported (IBNR) amount. This amount is actuarially calculated based on several factors including a claim lag triangle and is usually a part of the total expense calculation.

Passport MLR Calculation

Passport supplied an MLR spreadsheet containing the MLR data, by month, from January 2008 through June 2011. It appears that this MLR information relates to the Medicaid line of business only. We noted a number of limitations with the spreadsheet which may impact any findings of this analysis. Those limitations include:

- The MLR spreadsheet contains basic formulas but does not provide detailed calculations or details specifying which items are included in the income or expense numbers shown. Passport subsequently has provided some details regarding the medical expense calculation; however, it does not appear that all of the elements of the MLR calculation are detailed in the additional documentation submitted.

- We are unable to confirm the reasonableness of any methodology used to allocate shared administrative expenses between the Medicaid and the Medicare lines of business.

- The enrollment revenue is included on the spreadsheet; however, there is no information regarding how this enrollment revenue number is derived or adjustments made to the review amount and therefore we are unable to confirm the accuracy of this number.

- No clear explanation or supporting documentation was provided as to how the expenses are allocated between the administrative and other expense categories.

- Passport did not include a claim lag triangle or any other supporting documentation regarding how they calculate the IBNR amounts which are included in the medical expenses spreadsheets they provided to Myers and Stauffer.

During a conference call, Passport representatives initially indicated that reimbursements to member hospitals, which were related to their initial investments, were recorded as a medical expense. However, after further questioning regarding the recording of these reimbursements, Passport provided the following response:

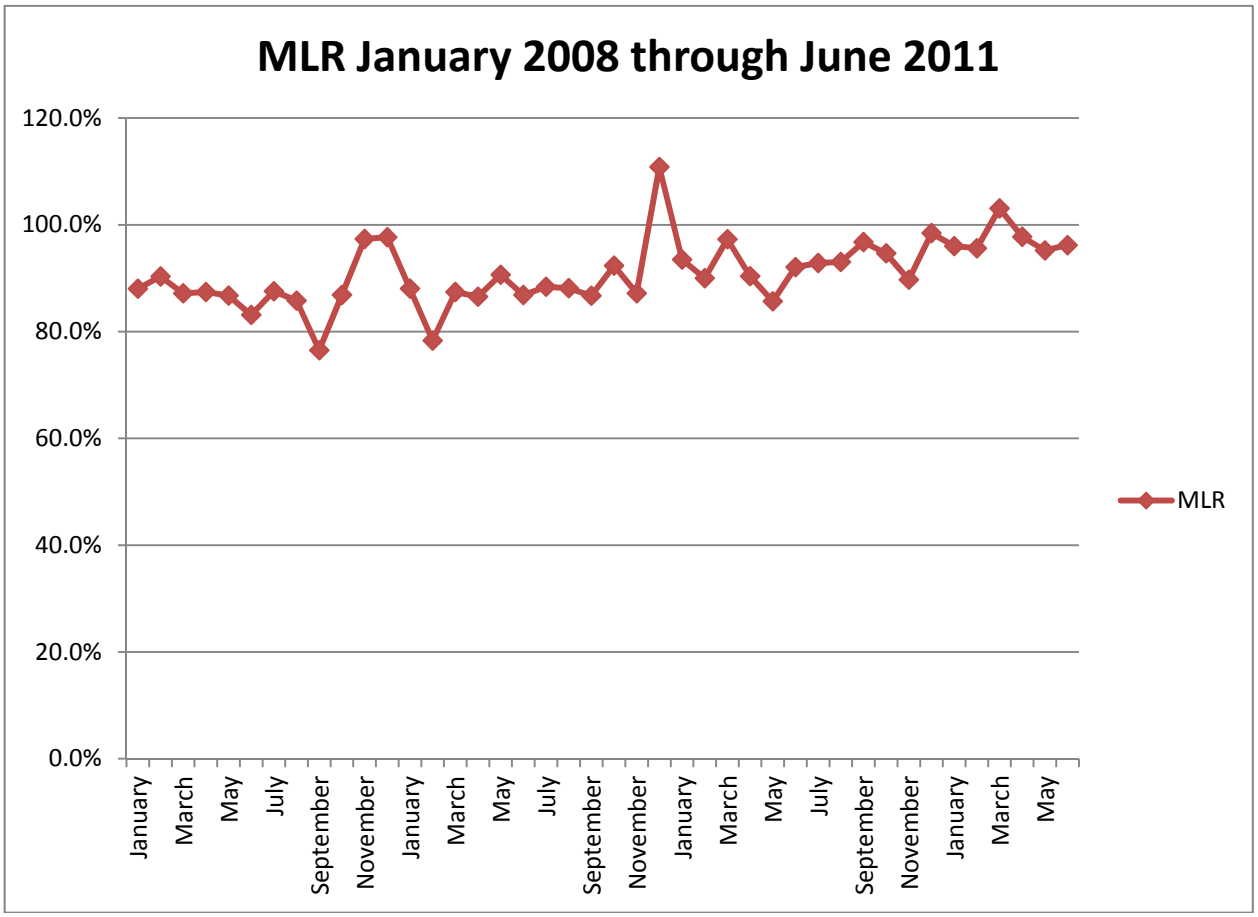
> This observation is not correct. The identified transactions were not recorded as medical expense. In 2008 when Passport returned the original investments ($10.5 million) to the plan's sponsors, this transaction was recorded as an adjustment (decrease) to surplus and was clearly reported as such in UHC's 2008 financial reports. Copies of these 2008

> financial reports were provided to DMS. In our 2011 financial statements, we will again report the repayment of these payouts as an adjustment (increase) to surplus. Copies of our 2011 financials will be provided to DMS.

Passport's MLR has been increasing over the last three years (see Chart 1C-1). In July 2008, the monthly MLR was calculated at 87.6 percent. By June 2011, the monthly MLR calculation was 96.2 percent. In December 2009 the MLR exceeded 100 percent. The net loss for this particular month was over $12 million. In reviewing the detail general ledger for medical expenses provided by Passport, we noted several items for which we are unable to confirm the exact nature of payments and the accuracy of classification of those payments. Information regarding possible year-end adjustments and accruals was not provided and therefore we are unable to identify the potential impact any of these items might have on this calculation. During following discussions with PHP, the health plan provided the following:

> Medical expenses include all payments to providers (e.g. hospitals, physicians, ancillary) and subcontracted providers (dental, vision, pharmacy). It also includes payments for medical education, safety net, urban trauma center, intensity operating allowance and reinsurance. Medical expenses are reviewed and accrued throughout the year. There are no special year-end adjustments.

Chart 1C-1: Passport Health Plan MLR, January 2008 through June 2011



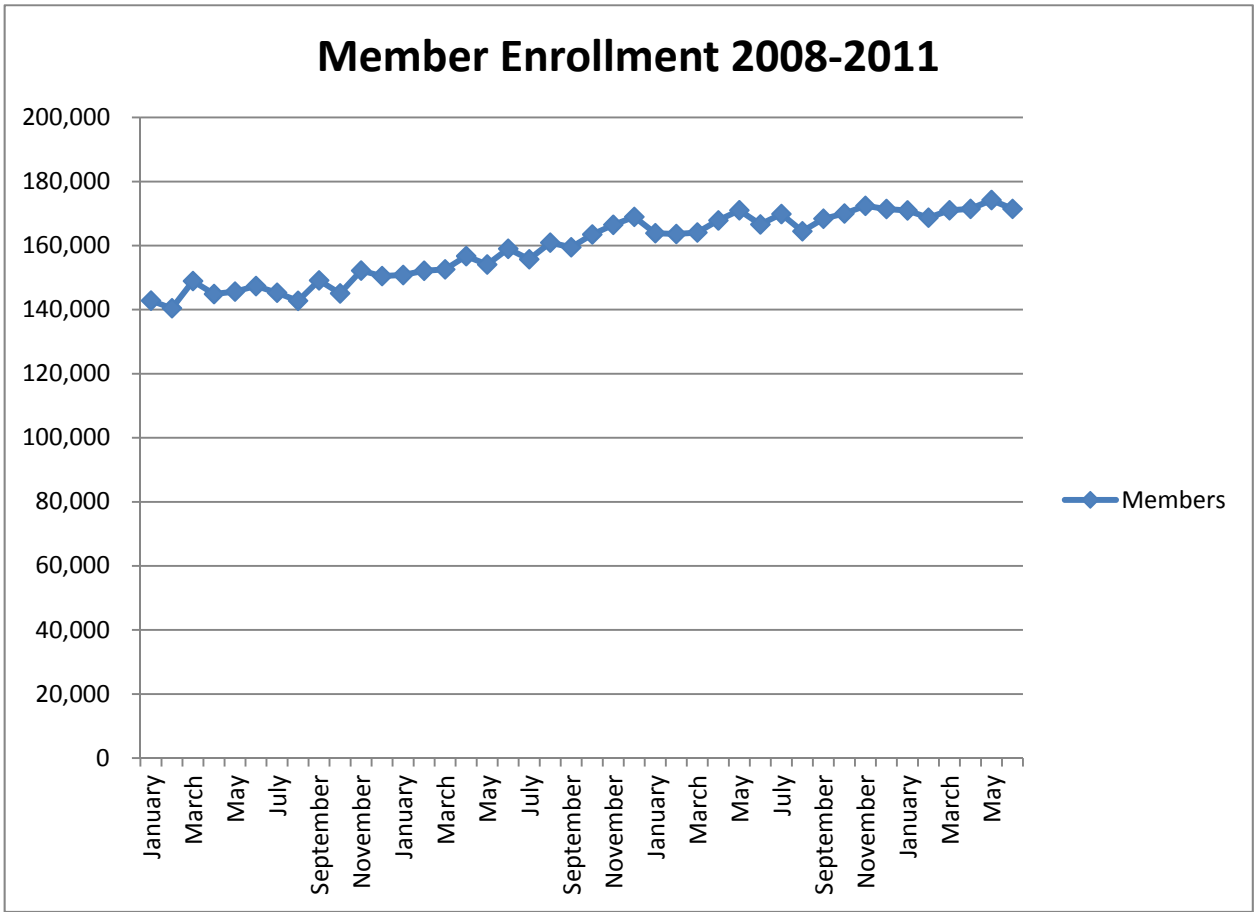
The Public Health Service Act of 2010 gives the National Association of Insurance Commissioners (NAIC) the task of developing uniform definitions and standard methodologies for calculation of the MLR for plan years 2011, 2012, and 2013. These standards will allow for rebates to consumers if the health plans do not comply with the MLR minimum established for small group and individual plans or large plans, which are 80 percent and 85 percent, respectively. There are forms in the NAIC documentation that a plan should use to generate an MLR to submit to the Department of Insurance in the plan's state. Although Passport's current contract with DMS requires that the NAIC form and content be utilized to report financial measurements, the contract does not specify that the health plan must meet the minimum MLR outlined by the NAIC.

Member Enrollment and Medical Expense per Member

The reported member enrollment for the time period being analyzed is shown below in Chart 1C-2. Enrollment has generally trended upwards since January 2008. Theoretically, with increased member enrollment, a plan will have increased medical

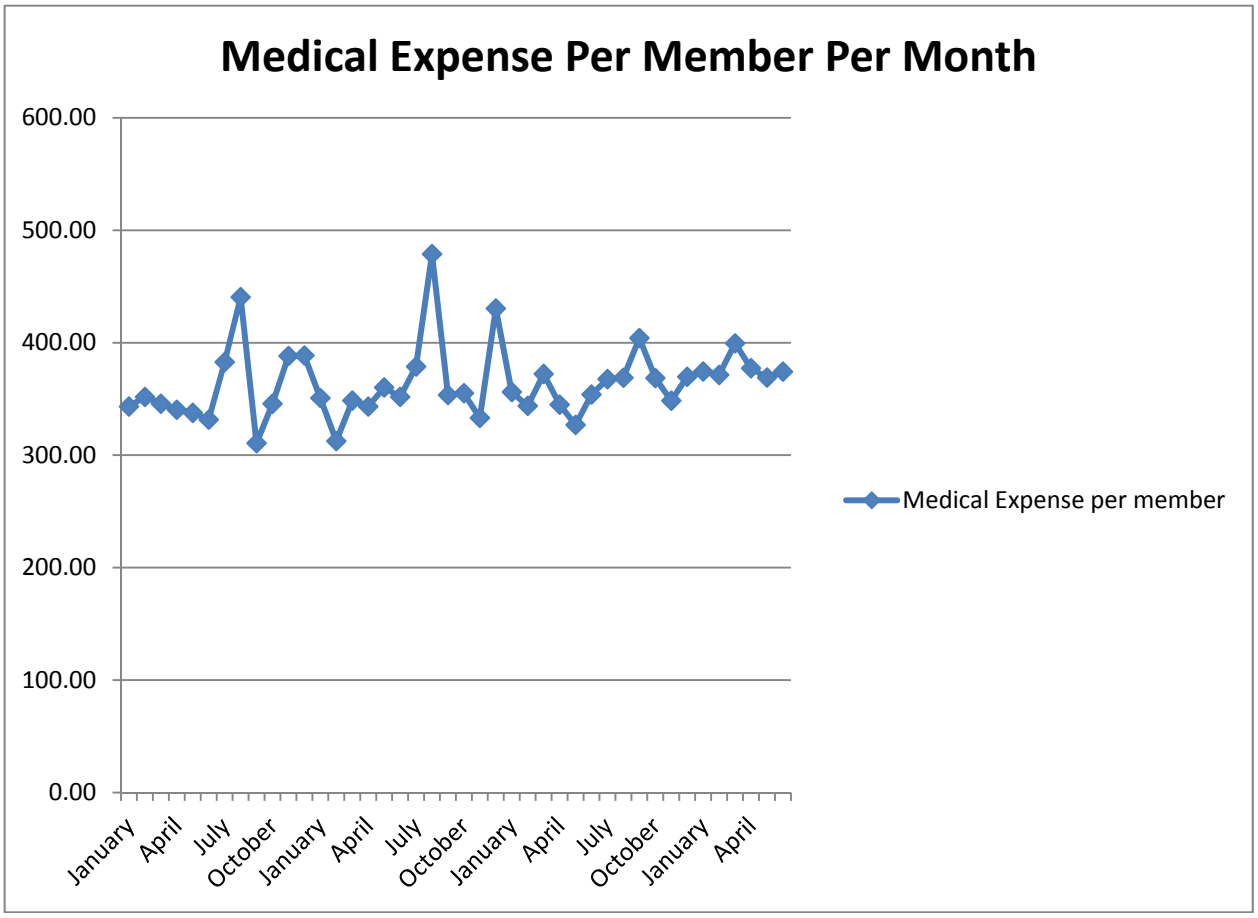
expenses but will also receive additional per member per month capitation revenue to offset the medical expenses. However, if the members who are added to the plan are in need of greater volume or higher intensity medical care, the risk pool may not be able to offset the increase in medical expenses and the MLR will increase as well.

Chart 1C-2: Member Enrollment, January 2008 through June 2011



In Chart 1C-3 we noted that medical expenses per member fluctuated throughout the year, as would be expected with illnesses such as influenza that are subject to seasonal variances. The three dramatic increases in Graph 3 are in August 2008 with medical expenses of $440.61 per member, August 2009 with medical expenses of $478.87 per member, and December 2009 with member expenses of $430.42 per member. More in-depth analysis will be required to identify the expected seasonal variances and other unanticipated variances.

Chart 1C-3: Medical Expense per Member Per Month



Analysis of Selected Medical and Administrative Expenses

Membership and Association Dues

During the period being analyzed, Passport reported paying approximately $227,000 in corporate and individual memberships. The largest portion, over $200,000, was related to national and state associations which Passport stated provided "industry information including legislation that affects Medicaid health plans."

Travel and Related Expenses

Passport reported expenditures of approximately $188,000 during the three-year period being analyzed with a large portion of those expenditures being in the form of

payments, over $85,000, to a Republic Bank credit card. Because the supporting detail for those credit card payments was not provided to us, we are unable to determine that the costs were reasonable and appropriate. UHC did not have a travel expense policy during the examination period. Upon review of Passport's other travel related policies and procedures, we noted that prior to July 1, 2011 the expense report policy dealt exclusively with the requirements for completing the expense report. Since that time, Passport provided a revised travel policy which appears to focus more on directing travelers regarding the use of economical travel options and the required approval processes.

Sponsorships

University Health Care, Inc.'s Articles of Incorporation reserve Passport's ability to, among other things, "give, donate, and contribute to any of the activities it may elect to sponsor." A review of the general ledger account containing sponsorship expenses indicates that Passport sponsored approximately $120,000 in 2008, $165,000 in 2009, $135,000 in 2010 and $13,000 through June 30, 2011. Of these amounts, approximately $22,600 in 2008, $16,500 in 2009, and $16,950 in 2010 were paid to one of Passport's own member organizations or to a foundation established by the member organization. The payments included sponsorships for golf tournaments and formal dances.

We also noted sponsorships to entities that may not provide a benefit to Passport Medicaid members. These sponsorships include the Kentucky Derby Festival, the Kentucky Opera and the South Lexington Babe Ruth League. It does not appear that any sponsorships were paid to the members organizations or related foundations from January 1, 2011 through June 30, 2011. In August 2011, Passport implemented a new policy that imposes additional fiscal responsibility and mission-directed consideration when making donation and sponsorship decisions.

Analysis of Compensation

Executive Compensation

We requested that Passport complete and submit a survey of executive compensation and benefits for the period being analyzed. It is noted that in certain instances, the Passport executives were not Passport employees but rather individuals whose services were procured under leasing arrangements with the University of Louisville and UPA. It appears that one executive, Dr. Larry Cook, did not receive compensation in his role as Chief Executive Officer. Passport offered the following information relative to our inquiries regarding Dr. Cook:

> Dr. Cook served as Chairman of the Board and Chief Executive Officer of University Health Care, Inc. While he held the CEO title and in [sic] some cases acted as the CEO, his duties were more consistent with the position of Chairman of the Board. In effect, most of the duties normally assumed by a CEO were performed by the Executive Vice President or equivalent (Robert Slaton held this position until succeeded by Shannon Turner) and

> the Executive Director of the principal subcontractor, AmeriHealth Mercy Health Plan. We have not found any written documentation that indicates the reason Dr. Cook was not paid for the aforementioned services. Also, we did not find any written documentation indicating that Dr. Cook ever sought compensation as CEO or Chairman of the Board.

For purposes of this analysis, "compensation" also includes amounts paid by Passport to outside entities, such as the University of Louisville, for individuals providing services under leasing arrangements. We requested that Passport provide supporting documentation and industry guidelines which were used to establish their compensation levels paid to executive staff. We received the following response:

> We have reviewed our files and discussed this request with our staff. We did not find any written copies of any industry standard guidelines or other tools used by PHP in determining the reasonableness of PHP executive compensation, including non-salary benefits for the time period of July 1, 2008 through June 30, 2011. Our understanding in regard to compensation is as follows:
>
> Prior to July 1, 2011, leased employees were compensated based on the guidelines established by the University of Louisville and University Physician Associates, whichever was applicable.
>
> The UHC Board utilized an outside expert in determining the reasonableness of the compensation arrangement for the Interim Chief Executive Officer.
>
> In August 2011, the UHC Board established the Executive Compensation Committee that amongst its responsibilities is to review and determine the reasonableness of PHP executive compensation.

During our attempts to determine the reasonableness of the compensation, we obtained the Forms 990 filed by Passport that included financial information regarding annual budgets. Based on that information, we determined the reasonable range for executive compensation based on industry standards and other resources. Our analysis determined that the compensation paid to the former executives by Passport was comparable to similar health plan executive compensation within the industry. While the compensation paid to the former executives of Passport does not appear excessive, it is important to note that we understand that at least one of the former Passport executives who received a salary, Shannon Turner, also held a number of other consulting positions and co-owned a consulting practice at the same time she stated she was a full-time Passport leased employee.

Severance Agreements

We reviewed several severance agreements with select Passport executives and employees. Our analysis determined that these agreements contain terms and payments that could be considered generous. During the course of our analysis and

interviews, we became aware of one employee who, according the interviewees, exited Passport "voluntarily" and received a severance package that included, among other things, one year's salary. This severance agreement contained a confidentiality clause prohibiting the former employee from discussing the terms of the agreement with anyone outside of Passport. The former employee did not respond to our request for an interview despite Passport communicating a waiver of the confidentiality clause contained in the agreement. We obtained copies of severance agreements that included terms such as paying the annual salary for up to three years after the termination of employment. Subsequent discussions with PHP indicated that the terms of the severance agreements were arrived at under legal advice and appear to have been carefully evaluated for sound business practices prior to execution.

AMHP Bonuses

AMHP provided information related to two types of bonuses paid to management and associates providing services related to Passport. Between 2008 through 2010, management staff received "Management Incentive" bonuses ranging from approximately $1,300 to $124,000. Associate staff received an "All Associate Bonus" beginning in 2010. These bonuses ranged from approximately $375 to $1,750. AMHP provided the following summary of bonus payments.

Table 1C-1 Summary of Passport Bonus Payments

Period / Year (begin and end dates)	Bonus Pool Category	Criteria for Eligibility	Number of Associates	Total Amount Paid
1/1/2008 - 12/31/2008	2008 Management Incentive Bonus	Performance	54	$796,855.33
1/1/2009 - 12/31/2009	2009 Management Incentive Bonus	Performance	55	$1,007,452.72
1/1/2010 - 12/31/2010	2010 Management Incentive Bonus	Performance	42	$607,902.38
1/1/2010 - 12/31/2010	2010 All Associate Bonus	Performance	158	$120,821.00

Analysis of Expenditures for Compliance to the Contract between Passport and DMS

The contract between DMS and Passport contains a number of provisions related to expenditures including those listed on the table below.

Table 1C-2 Select Contract Provisions Relating to Expenditures Made by Passport

Contract Reference	Page	Contract Language
7.6	94	Related to Marketing: The Contractor may conduct Member Marketing and Enrollment activities only with Recipients residing in the Partnership's Region. The Contractor is prohibited from point-of-sale marketing to Recipients. The Contractor shall establish and at all times maintain a system of control over the content, form, and method of dissemination of its Marketing and information materials. The Contractor shall submit any marketing plans and all marketing materials to the Department and shall obtain the written approval of the Department prior to implementing any marketing plan or arranging for the distribution of any marketing materials to Recipients. The Contractor shall include in the plan the methods and procedures to log and resolve marketing Grievances. The Contractor may conduct mass media advertising directed to Recipients in the Partnership Region pursuant to a marketing plan and using marketing material(s) that have been first submitted to and approved, in writing, by the Department. The following are inappropriate marketing activities, and the Contractor shall not: (a) Provide cash to Members or potential Members, except for stipends, in an amount approved by the Department and reimbursement of expenses provided to Members for participation on committees or advisory groups; (b) Provide gifts or incentives to Members or potential Members unless such gifts or incentives: (1) are also provided to the general public; (2) do not exceed ten dollars per individual gift or incentive; and (3) have been pre-approved by the Department; (c) Provide gifts or incentives to Members unless such gifts or incentives: (1) are provided conditionally based on the Member receiving preventive care; (2) are not in the form of cash or an instrument that may be converted to cash; and (3) have been pre-approved by the Department; (d) Seek to influence a potential Member's enrollment with the Contractor in conjunction with the sale of any other insurance;
14.6	128	Related to Termination for Cause: (g) Gratuities other than de-minimus or otherwise legal gratuities are offered to, or received by, any public official, employee or agent of the Commonwealth from the Contractor, its agent's employees, Subcontractors or suppliers, in violation of Section 17.2 of this Contract.
17.2	134	Related to Offers of Gratuities/ Purchasing and Specifications: The Contractor certifies that no member or delegate of Congress, nor any elected or appointed official, employee or agent of the Commonwealth, the Kentucky Cabinet for Health and Family Services, CMS, or any other federal agency, has or will benefit financially or materially from this procurement. This Contract may be terminated by the Department pursuant to Section 14.6 herein if it is determined that gratuities were offered to or received by any of the aforementioned officials or employees from the Contractor, its agents, employees, Subcontractors or suppliers. The Contractor certifies by its signatories hereinafter that it will not attempt in

Contract Reference	Page	Contract Language
		any manner to influence any specifications to be restrictive in any way or respect or will it attempt in any way to influence any purchasing of services, commodities or equipment by the Commonwealth. For the purpose of this paragraph, “it” is construed to mean any person with an interest therein, as required by applicable law.
17.15	145	Related to Prohibition on Use of Funds for Lobbying Activities: The contractor agrees that no funding derived directly or indirectly from funds pursuant to this contract shall be used to support lobbying activities or expenses.
4.49	26	Related to Certification of Lobbying Activities (Lines 1372-1375): Second Party shall disclose any lobbying activities in accordance with Section 1352, Title 31, U.S. Code. The Second Party certifies, to the best of his or her knowledge and belief that: No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Members of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form - LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

We analyzed the detail general ledger accounts provided by Passport and any information provided by AMHP in an attempt to ensure compliance with the contract provisions listed above. Although requested, Passport has not provided the complete detail general ledger for the period being analyzed that was requested on October 7, 2011. Therefore, certain expenditures may have been made which were not in compliance with the provisions included above.

Marketing and Advertising Expense

The detail provided by Passport for the time period being analyzed included only two items totaling $1,225 for marketing and advertising expense. While neither of these items appears to conflict with the contractual provision noted above, it was unclear whether this constituted all marketing and advertising expenditures made for the three years being analyzed. Passport confirmed the accuracy of this amount stating:

> Since during the audit period Passport had a sole-source contract with the state and DMS was responsible for determining the members to be enrolled in the Passport program, our need to market or advertise was minimal. The report as provided is correct.

Gratuities

Passport indicated that it does not have a policy in place regarding gratuities during the period of the examination but that a policy has now been implemented.

Lobbying Expense

When asked to provide a copy of Passport's internal policy regarding lobbying expense, Passport provided the following response:

> We have reviewed our files and discussed this request with staff. We did not find any policies and procedures for lobbying activities and contributions to political parties, political action committees, campaigns, or other organization involved in local, state, or federal elections for University Health Care, Inc. for the requested time period, January 2008 to current. However, Passport does comply with Section 16.15, Prohibition on Use of Funds for Lobbying Activities, found in its current contract with DMS.

Passport reported paying $431,406 in lobbying costs during the period being analyzed. Two firms, Southern Strategy Group and Roll Call Strategies, LLC, received nearly 88 percent of those funds.

Compliance with Regulations, Statutes, and Policies Applicable to Not-for-Profit Entities

Myers and Stauffer consulted with attorneys from Krieg DeVault (KD), a law firm with extensive expertise in healthcare related matters, including Medicaid managed care plans and not-for-profit entities, to analyze Passport's level of compliance with 1) federal and state Medicaid regulations, rules, waivers and statements; 2) relevant not-for-profit maxims as well as Passport's own articles of incorporation and bylaws; and 3) the provisions of the contract between Passport and the Department for Medicaid Services for SFY 2011. *Please note that the analysis conducted by KD does not constitute a legal opinion and was provided based on the applicable standards for consulting engagements.*

The evaluation conducted by KD and the associated findings are included in the table below.

Table 1C-3 Analysis of Regulatory and Contractual Compliance

Compliance Area	Requirement(s)	Finding
Medicaid Managed Care Rule, 42 CFR 438	Varying requirements based on health plan type regarding requirements, prohibitions and procedures for the provision of Medicaid services. Includes program integrity, conflict of interest safeguards, quality measures and member grievance and appeal processes.	The various requirements of this Rule are contained in the contract in effect between DMS and Passport.
Section 1115 Medicaid Waiver	Contains the provisions which detail how the federal regulations are "waived" in order to allow Passport to operate in Region 3.	No instances were noted that would indicate Passport has violated any of the waiver provisions.
42 CFR 434.6 and 434.70; 45 CFR Part 74, Medicaid Contract Requirements	Federally mandated contract provisions	1) Because of the lack of certain written contracts for subcontractors, Passport may be in violation of 42 CFR 434.6 which requires that all subcontracts be in writing and for the subcontracts themselves to also meet the requirements of federal contracting laws. 2) 42 CFR 434.40 states that capitated contracts that are a year in duration should not be renegotiated during the term. Additional information provided appears to indicate that PHP is in compliance with this provision.
Kentucky Not-For-Profit Laws, KRS §273.161	Defines the purposes for which a nonprofit corporation may be formed, general powers and requirements for formation, as well as provisions for subsequent changes and modifications to the organization and distribution of assets.	It appears that Passport complies with federal and state not-for-profit requirements.
Contract between DMS and UHC/Passport for SFY 2011	The contract contains provisions which require full disclosure of Passport's subcontractors' subcontractors to DMS which in one fiscal year exceed the lesser of $25,000 or 5% of the subcontractor's operating expense.	With the current provision, Passport would not be required to disclose to DMS certain subcontractors who fall below the dollar/percentage threshold stated.
Contract between DMS and UHC/Passport for SFY 2011	Section 1.3 does not allow Passport to delegate away its responsibility for contract requirements, including documenting in writing activities which are delegated and the reporting responsibility of the subcontractor.	During interviews with staff, it appears that the understanding of delegation of duties and the responsibility for those duties was inadequate during the audit window.

Compliance Area	Requirement(s)	Finding
Contract between DMS and UHC/Passport for SFY 2011	Section 10.2 requires Passport to agree in writing to produce any additional information not already contemplated in Attachment X of the contract. Section 10.9, however, states that Passport agrees to make available all "Records" (see contract for items considered "Records"), without limitations.	As written, this first provision may act as a shield to Passport from certain requests from the State and from entities acting on behalf of the Commonwealth and/or DMS. However, the second provision would require Passport to provide access to all records.
Contract between DMS and UHC/Passport for SFY 2011	Section 10.7 relates to Ownership and Financial Disclosure	By agreeing to the provisions of 42 CFR 455.104, Passport agrees to provide information concerning ownership interests and transactions with its Members and Board of Directors.
Contract between DMS and UHC/Passport for SFY 2011	Section 4.26 indicates that Passport is required to follow certain cost reimbursement principles.	Federal law does not permit administrative costs to be reimbursed separately from the per member per month risk payment. Therefore, this language may not be applicable.

PHP and/or AMHP provided the following commentary related to 42 CFR 434.40 and 42 CFR 434.60.

> The requirements in the sections of the Code of Federal Regulations (CFR) that are cited in the DMS audit report do not apply directly to a health plan such as PHP. Instead, these requirements apply to a state agency such as the Department of Medicaid Services (DMS) that administers a state plan for medical assistance that has been approved by the Centers for Medicare & Medicaid Services (CMS). Further, the cited sections of the CFR do not apply indirectly to a health plan such as PHP that is classified as a managed care organization (MCO), because contracts between a state agency and an MCO are governed by a different part of the CFR. The following is a summary of the statutes and regulations that support these conclusions.
>
> Section 1902(a)(4) of the Social Security Act, codified as 42 U.S.C. 1396a(a)(4), provides in relevant part that a state plan for medical assistance must "provide such methods of administration ... as are found by the Secretary to be necessary for the proper and efficient operation of the plan." The term "Secretary" refers to the Secretary of Health and Human Services (HHS).
>
> The regulations issued by HHS relating to various issues are found in Title 42 of the CFR. The regulations in Chapter IV of Title 42, as set forth in Parts 400 through 505, deal generally with CMS. The regulations in Subchapter C of Chapter IV, as set forth in Parts 430 through 456, deal specifically with medical assistance programs. The scope of the regulations in Subchapter C is defined in 42 CFR 430.1 as follows: "The

regulations in subchapter C set forth State plan requirements, standards, procedures, and conditions for obtaining Federal financial participation (FFP)." The two sections of the CFR that are cited by Myers and Stauffer, 42 CFR 434.6 and 42 CFR 434.40, are contained within Subchapter C and therefore those two sections are within this defined scope.

Further, the two sections of the CFR that are cited by Myers and Stauffer are contained within Part 434 of Subchapter C. The scope of Part 434 is defined in 42 CFR 434.1(b) as follows: "This part sets forth the requirements for contracts with certain organizations for furnishing Medicaid services or processing or paying Medicaid claims, or enhancing the agency's capability for effective administration of the program." In addition, 42 CFR 434.4 provides as follows: "If the state plan provides for contracts of the types covered by this part, the plan must also provide for meeting the applicable requirements of this part."
We also reviewed the regulations to determine if they apply indirectly to PHP, in other words, whether the PHP contract with DMS is the type of contract that is described in the regulations that are cited in the DMS audit report.

The first regulation cited in the DMS audit report, 42 CFR 434.6, sets forth requirements for "all contracts under this part." There are three types of contracts that are covered by Part 434: (A) contracts with fiscal agents, which are covered by 42 CFR 434.10; (B) contracts with private non-medical institutions such as child care facilities or maternity homes, which are covered by 42 CFR 434.12; and (C) contracts with health insuring organizations that are not subject to the requirements in section 1903(m)(2) of the Social Security Act, which are covered by 42 CFR 434.40. The PHP contract with DMS is not one of these types of contracts. PHP is not a fiscal agent, PHP is not a private non-medical institution, and PHP is subject to the requirements in section 1903(m)(2), which is codified as 42 U.S.C. 1396b(m)(2).

The second regulation cited in the DMS audit report, 42 CFR 434.40, as mentioned above, covers contracts with health insuring organizations that are not subject to the requirements in section 1903(m)(2) of the Social Security Act. As mentioned above, PHP is subject to the requirements of this statute. The current contract between PHP and DMS states in the second "WHEREAS" clause on page 1 that PHP "is eligible to enter into a risk contract in accordance with Section 1903(m) of the Act and 43 CFR 438.6 [and] is engaged in the business of providing prepaid comprehensive health care services as defined in 42 CFR 438.2."

It will be noted that the above-mentioned "WHEREAS" clause contains citations to several CFR regulations that are contained in Part 438 of Subchapter C, Chapter IV, Title 42. The title of Part 438 is "Managed

> Care" and the regulations in Part 438 set forth the requirements for a state plan with respect to MCOs. The regulation in Part 438 that deals specifically with the state plan requirements for a contract between a state agency and an MCO is 42 CFR 438.6.
>
> In summary, the regulations … do not apply to PHP, either directly or indirectly. The contract between DMS and PHP is subject generally to the regulations in Part 438 of Subchapter C, Chapter IV, Title 42 of the CFR, and is subject specifically to the contract requirements set forth in 42 CFR 438.6.

Analysis of Profitability

We analyzed the audited financial statements submitted by Passport for 2007, 2008, 2009 and 2010 and identified components of those statements that would allow us to assess the profitability of Passport utilizing certain profitability ratios. Profitability ratios measure the overall impact of operating decisions on the health plan's financial condition. Please note that the audited financial statements include cumulative financial data for all of Passport's lines of business, including its Medicare Advantage product. Insufficient detail was available to analyze the Medicaid managed care line of business alone.

For purposes of this analysis, "profit" is defined as the excess of all revenues indicated on the financial statements over expenses. Revenues include premiums earned, interest and dividend income, net realized investment gains (losses) and the net realized gains (losses) from the sale of investments. Expenses include all medical and administrative expenses as well as any adjustments to the premium deficiency reserves. Our analysis identified the following financial components:

Table 1C-4 Key Elements from Passport Audited Financial Statements

Description	2007	2008	2009	2010
Total Revenues	$752,850,780	$834,229,884	$913,841,582	$922,340,730
Net Income from Operations	$ 20,519,176	$ 2,376,162	$ 6,520,201	$ 6,135,834
Net Unrestricted Assets	$ 90,258,748	$ 79,953,078	$ 90,270,981	$109,059,998
Current Assets	$142,068,695	$129,686,594	$138,153,318	$107,218,491
Total Assets	$195,452,666	$181,665,388	$199,441,272	$211,031,424
Total Liabilities	$106,193,918	$101,712,310	$102,170,291	$101,971,426

Utilizing the key elements above, we calculated the selected profitability ratios shown below.

Table 1C-5 Selected Passport Profitability Ratios

Ratio	2007	2008	2009	2010
Return on Assets Ratio	10.5%	1.3%	3.3%	2.9%
Current Ratio	133.8%	127.5%	135.2%	105.1%
Debt Ratio	54.3%	56.0%	51.2%	48.3%
Total Margin	2.7%	0.3%	0.7%	0.7%
Operating Margin	2.8%	0.3%	0.7%	0.7%

Return on Assets Ratio

This ratio is a measure of how effectively the health plan's assets are being used to generate profits. Generally, the higher the percentage, the better the health plan is at generating profits utilizing the total assets of the health plan. With the exception of 2007 during which the ratio was 10.5 percent, Passport's return on assets has been positive but remained low.

Current Ratio

The current ratio is the relationship of current assets to current liabilities. Generally speaking, short term creditors find a high current ratio favorable as it is an indication that a borrower has a greater ability to pay short term liabilities. Shareholders and other investors would rather see a lower (but still positive) current ratio as it indicates the entity is using current assets to grow the business. Passport's current ratio is above 100 percent in each year, indicating the health plan's current assets exceeded their current liabilities.

Debt Ratio

The debt ratio is a reflection of the total debt of the health plan to the total assets at a given point in time. Passport's debt ratio has remained rather constant, averaging 52 percent across the period being analyzed.

Total Margin

The total margin is calculated by dividing net income by total revenue. The ratio is used as an indication of a health plan's ability to control expenses. For example, in 2007, for each dollar of revenue that Passport received, the plan generated 2.7 cents in profit. Generally, the higher the total margin, the better. It is important to note that non-operating revenues and expenses are included in this ratio, so it is possible that a plan could be operating at a loss and, if non-operating revenue is large enough, still show a positive total margin.

Operating Margin

The operating margin measures profitability as a percentage of operating revenue, or in this case, premiums earned. Similar to the total margin, this ratio focuses on the core operations of the health plan and removes the influence of non-operating revenues and

expenses. Passport's operating margin is nearly identical to the total margin, indicating that investment gains (losses) and interest and dividends had minor impacts in the years analyzed.

The profitability analysis appears to indicate that Passport has, in fact, operated profitably during the years being analyzed but only slightly above a breakeven level. This analysis assumes that the expenses included on the audited financial statements were reasonable and prudent.

As mentioned in the assumptions and limitation section of this report, the audited financial statements used in this analysis are cumulative and include all of Passport's lines of business, including its Medicare Advantage line. Utilizing the data provided by Passport on the MLR spreadsheet, which appears to include only Medicaid data, we can calculate the total and operating margins for comparison. Note that 2007 MLR data was not requested and Passport provided MLR data through July 2011. These calculations are shown below.

Table 1C-6Estimated Total and Operating Margins for Passport Medicaid Line of Business

Ratio	2008	2009	2010	YTD 2011
Total Margin	-1.4%	0.8%	0.7%	3.4%
Operating Margin	0.4%	0.0%	0.2%	1.3%

In 2008, Passport recorded investment losses of $11.8 million and included these on the Medicaid MLR it provided to us. Therefore, the total margin shown above reflects the impact of these losses. As with the overall profitability ratios, the Medicaid line of business also shows weak profitability margins.

Analysis of Any Foreign Accounts

As of September 6, 2011, Passport reported approximately $215 million in cash and investments. Initial information provided by Passport indicated that these investments were all domestically domiciled. However, we noted that the June 10, 2008 Board meeting minutes included mention of the selection of an international equities investment manager. Upon further inquiry, Passport confirmed that a portion of the health plan's invested assets, approximately 10 percent, are allocated to international equities. These investments are managed by Manning & Napier, an investment management firm headquartered in Fairport, New York. No other indications of foreign investments were located in the information provided by Passport.

√ Observations, Findings or Recommendations Related to Revenue, Compensation and Expenditures

1) Interviews with Passport indicated there currently are no formal quality assurance processes related to financial management or reporting. Passport should develop and document such quality assurance processes.

2) We were unable to confirm the reasonableness of any methodology used to allocate shared administrative expenses between the Medicaid and the Medicare lines of business. Passport should document this process in order to ensure that future staff have a clear understanding of the allocation process and can demonstrate compliance.

3) During the period being analyzed, Passport reported paying approximately $227,000 in corporate and individual memberships. The largest portion, over $200,000, was related to national and state associations which Passport stated provided "industry information including legislation that affects Medicaid health plans". Passport should consider a policy that would require that the benefits of these memberships be demonstrated.

4) During the audit period, we noted sponsorships to entities that may not have provided a benefit to Passport Medicaid members. It appears that Passport is working to develop a more fiscally-responsible mind-set when the decision to make sponsorships is undertaken to ensure sponsorships are for the benefit of the health plan's members and has implemented a sponsorship and grants policy.

5) PHP indicated that it has implemented an executive compensation committee and engaged an outside consultant to ensure that it is able to adequately demonstrate that executive compensation has been thoroughly evaluated and is comparable to similar positions within the industry.

6) It was noted that certain former Passport employees received severance packages which could be considered generous. While Passport indicated that these severance agreements were arrived at based on sound legal advice, we recommend that Passport develop policies regarding severance packages including, which staff is eligible, under what circumstances will severance be paid and a reasonable basis for calculating the severance amount that is paid.

7) Because of the lack of certain written contracts for subcontractors, Passport may be in violation of 42 CFR 434.6 which requires that all subcontracts be in writing and for the subcontracts themselves to also meet the requirements of federal contracting laws. PHP provided commentary that disputed the

consulting analysis from Krieg DeVault. DMS may wish to consult the Department's legal counsel on this matter.

Objective 1D: Provider and Member Complaints and Concerns Regarding Passport Health plan

The objective of this analysis is to examine complaints/concerns related to Passport and its subcontractors, including:

a. Determining validity of specific complaints/concerns received by the Cabinet or the APA related to the business practices of Passport and for its subcontractors.
b. Verifying and validating the process for accessing/addressing the complaints/concerns, the outcomes and resolutions of the complaints/concerns.

The methodology utilized in the review of complaints employed various techniques, such as inquiry, review, analytical testing, compliance considerations, and in some cases, external confirmation. Each technique applied was used to gather corroborating evidence that when analyzed, and reviewed, would allow us to reach certain conclusions relating to the overall complaints and grievances processes utilized by PHP.

In preparation for reviewing and analyzing the complaints related to Passport, we performed the following procedures:

1) Reviewed complaint documents provided by DMS;
2) Obtained complaint documents submitted by Passport;
3) Interviewed and obtained information from several provider associations;
4) Reviewed Passport complaint and grievance policies and procedures;
5) Compared Passport policies to applicable Federal and state regulations (42 CFR 438.406, 438.408, 438.410, and 438.414; and 907 KAR 1:671);
6) Compared Passport policies to provisions of their contract with DMS, including any subsequent amendments in effect during the period of this analysis;
7) Assessed compliance with policy; and
8) Analyzed complaint data submitted.

The following details the various steps performed during the analysis of grievances and complaints.

Review of Complaint Documents Provided by DMS

DMS provided Myers and Stauffer with complaints received by the Office of Inspector General. The nature of these complaints varied but generally focused on provider or member complaints that might be typically found in a managed care program, such as "dissatisfied with auto-assignment" or "PCP (primary care physician) requests member be removed from panel." Both of these types of complaints are common in a managed care program because various circumstances occur that prompt a member to want to

change physicians and vice versa. The complaints provided also included those submitted to the APA prior to its audit of University Health Care, Inc., or Passport Health Plan.

Complaint Documents Obtained from Passport Health Plan

During the course of our analysis, Myers and Stauffer requested considerable data and documentation from PHP. The request included a listing of all provider and member complaints, complaint and grievances policies and procedures, documents related to escalated complaints, and all associated policies. Each document was reviewed for reasonableness.

PHP appears to receive complaints in one of two ways: 1) through a telephone call, or 2) through written correspondence.

Member complaints received through a telephone call are logged into a contact service form. The PHP phone representative may be able to resolve the complaint while on the telephone with the member. In cases where an immediate resolution is not possible, the telephone representative will send the contact service form to a research technician. The research technician is then responsible to review the complaint, perform any research necessary, follow-up with the member and document the final complaint resolution.

Written complaints from members are also logged into the system where a research technician is assigned to the complaint. This staff member then has the responsibility to contact the member by telephone to discuss the complaint and attempt to arrive at a resolution.

Provider complaints are processed in a similar manner, with the complaint or appeal being logged into the electronic form referred to as an SF (service form), where staff members are assigned to research the issue and work with the provider to arrive at a resolution. There is also a separate process for complaints that, upon meeting certain criteria, are entered into an escalated complaints log. These are provider complaints submitted to PHP through email, letter, or telephone call that may involve external parties such as the PHP Board of Directors, the CEO of PHP, the Governor, the Department of Insurance, legislators, DMS, CMS, attorneys, press or media. When a provider's complaint is elevated to this level, PHP management is then included to arrive at a resolution to the provider's concerns.

We received a list of member complaints for the period under review from Passport. We subsequently requested that this file be provided in a format that would allow us to perform analytical procedures.

We also requested a list of provider complaints for the period being analyzed. PHP representatives indicated that provider complaints generally are not related to rate disputes, but rather relate to provider disagreements with denials, or other claim issues. A sample month of provider complaints was requested, but not received from PHP.

We received an escalated complaints log for the period under review. The log included 19 individual complaints. The log reflected that all the complaints are closed with the exception of one complaint involving mobile dental units. When asked about this issue, PHP stated that they are working on logistics of how this service might be implemented and also determining any other logistical and follow-up procedures that would need to be included in the process to ensure proper and coordinated care for the member.

Interviewed and Obtained Information from Providers and Provider Associations

We contacted five provider associations: 1) Kentucky Hospital Association, 2) Kentucky Primary Care Association, 3) Kentucky Pharmacists Association, 4) Louisville Dental Society, and 5) Greater Louisville Medical Society. While there appeared to be some hesitancy from the associations regarding the level of assistance the associations could provide, each association agreed to contact their members with our invitation to share their issues and concerns regarding PHP and to direct the providers to contact Myers and Stauffer directly. The associations were encouraged to submit to Myers and Stauffer complaints or concerns on behalf of their members. Information was obtained from two sources: 1) Greater Louisville Medical Society (GLMS) and 2) Kentuckiana Oral & Maxillofacial Surgery Associates, PSC (referred to hereafter as KYOMS), a member of the Louisville Dental Society.

GLMS indicated its members were generally pleased with Passport Health Plan and indicated that periodic meetings with representatives from Passport were held to discuss any issues that members brought to the association's attention.

KYOMS indicated they had experienced issues with Passport's third party dental administrators, initially Doral Dental Services of Kentucky and then Managed Care of North America of Kentucky (MCNA). The provider indicated that Doral and KYOMS had considerable disagreement regarding the coding of complex extractions for children. The provider stated that Doral would down code these claims and recoup a portion of the amount previously paid to KYOMS without providing an explanation nor requesting and reviewing additional dental record documentation. As a result of a dispute filed by KYOMS, Doral repaid a portion of the recoupments to KYOMS, with KYOMS foregoing further appeal on the balance. This grievance was included on the Passport log of "escalated provider complaints" on 5/29/2009. The log appears to document the complaint was resolved. However, the provider indicated that they have requested an additional meeting with Passport because a similar issue is now occurring with MCNA (as of October 2011). It appears that prior to the dispute filed by KYOMS, Passport management was not aware of this issue. PHP indicated that the contract with MCNA was terminated effective 3/21/12 and that there is a 180-day phase out of that contract.

Review of Complaint and Grievance Policies and Procedures

We reviewed Passport's complaint, grievance, and escalated complaint policies and procedures. Specifically we reviewed the following policies:

MS 14.01 – Member Services – Consistency Reviews of Call Documentation for Research Technicians

MS 11.0 – Member Services – Department Function

MS 16.0 – Member Services – Grievance Process

PC 18.0 – Provider Claims – Claim Appeal Process

PC 20.0 – Provider Services – Claim Documentation Requirements

PR 28.0 – Provider Relations – Coordination, Resolution & Communication of Escalated Provider Complaints

It appears that each policy is reviewed and updated as necessary at least annually and noted as such. We have requested various reports and information related to the above policies and those received are discussed later in this section.

Comparison of Policies to Federal Regulations (42 CFR 438.406, 438.408, 438.410, and 438.414); and State Regulations (907 KAR 1:671)

The comparison of Passport policies to the applicable sections of the Code of Federal Regulation indicated that Passport's policies appear to adequately address the requirements found in the regulations. For a copy of these regulations, please refer to Exhibit C. While we did not perform a detailed examination to validate PHP's compliance with every requirement of the CFRs, Passport's policies appear adequate to comply with federal regulations.

While we did not perform a detailed examination to validate every requirement in 907 KAR 1:671, we did note that one or more of Passport's subcontractors may potentially be noncompliant with the following requirement found in the regulation.
Kentucky regulation 907 KAR 1:671, section 2(10)(b) states,

> A timely-filed request of administrative appeal process shall stay the recoupments activities by the department pertaining to the issues on appeal until the administrative appeal process is final.

In accordance with DMS policy, an appeal or request for dispute resolution (i.e., grievance) typically will activate such "stay" on recoupment activity until the complaint is resolved. In accordance with the contract between Passport Health Pan and MCNA, section 3.5, MCNA shall cooperate in Member Grievance procedures and the process must comply with state regulation 907 KAR 1:671. The Passport contract with Doral included the same provisions.

In evaluating the KYOMS provider complaint described earlier, it appears that Passport's subcontractors may not be adhering to this regulation, even though the

requirement is included in the contract between the subcontractor and Passport. In addition, a requirement to comply with 907 KAR 1:671 is found in Passport's own policy on provider claim appeals. We questioned Passport regarding whether a provider's recoupments are placed "on hold" until any appeal is resolved. A response to our inquiry was not received from PHP.

Comparison of Passport Policies to the Contract in Effect between DMS and Passport

The comparison of Passport policies to the contract between DMS and Passport indicated that Passport's policies generally address the requirements found in the contract.

It was noted that in SFY 2011, the contract was amended to add item (h) in the paragraph related to program integrity, as noted below.

> The Contractor shall develop in accordance with Attachment VII, a Program Integrity plan concerning the establishment of internal controls, policies and procedures that are capable of preventing, detecting and deterring incidents of Fraud, Waste and Abuse. The required procedures shall include the following and be made available for review by the Department:
>
> **(h) Provision for internal monitoring and auditing of Contractor and its subcontractors; and supply the department with quarterly reports on the activity…**

We requested that Passport provide us with the policies and procedures related to the monitoring of subcontractors. Passport provided the policy document entitled "Oversight of Delegated Activity". References on this document indicate that it was developed in 1998 however information regarding subsequent amendments which may have been required to address changing contractual, regulatory or operational requirements are not evident in the documentation provided. We did receive a number of sample reports in which Passport sought to demonstrate its compliance with the contractual reporting requirements in its contract with DMS. No significant findings were identified; however, a more thorough analysis would be required to thoroughly assess Passport's compliance with its own policies related to the monitoring of its subcontractors.

Analysis of Passport Compliance with Policy

Throughout Passport's own policies, it appears that procedures that include monitoring, analysis, and reporting are in place. When asked, PHP representatives indicated these processes are occurring and that supporting documentation is available for review. Supporting documentation for specific months was requested by Myers and Stauffer to ensure compliance with policy.

Specifically requested items included the following:

1) Provider written appeals for the month of June 2010

2) Documentation submitted to corporate auditors for months June 2009, June 2010, and June 2011

3) Documentation supporting auditor / trainer reviews for quarters June 2010 and December 2010

4) Quarterly statistics on appeals reported to DMS for June 2010 and December 2010

5) Documentation supporting consistency reviews for November 2009

6) Documentation supporting analysis of review to determine trends on grievances based on race, ethnicity, and/or language

7) Monthly member grievance report for June 2010

8) Cumulative quarter report / statistics for June 2010

In response to the above request, Passport submitted documentation in response to items six, seven and eight. The remaining items were not submitted.

Analysis of Complaint Trends Based on Race, Ethnicity and/or Language

The report on the following page was submitted by Passport in response to item six above and seeks to demonstrate Passport's review of complaints based on race, ethnic and/or language.

Passport HEALTH PLAN

University Health Care, Inc.

3rd Quarter 2010
Race/Ethnicity and Language

Description of Report: 3rd quarter 2010 Analyzes of Race/Ethnicity and Language:

- Complaint categories around race/ethnicity/language
- Communication unclear/untimely
- Provider rude
- Office staff rude/inappropriate

Objective: To ensue that there are no trends or a problem with the network's ability to deliver culturally appropriate care to members based on their race/ethnicity/language.

Analysis: Based on this analysis there are no trends or problems with the network's ability based on member's race/ethnicity/language. If this information were to indicate discrimination based on race, language or ethnicity of the member, Member Services would document the incident and forward to Provider Services. The outcome of the investigate would then be forward back to Member Services so they can resolve the complaint with the member, which could result in a primary care provider change if the member so desired. The incident would also be shared with the Plan's culture and linguistics service coordinator so training be offered to the provider and office staff.

Member Grievances on Race/Ethnicity and Language

	3rd Qtr 2010
Total Overall Complaints	282
Race/White	199
Race/Black	69
American Indian/Alaskan	2
Asian	2
Other	10

Member Cultural Needs and Preferences

The Plan receives data on members' primary language spoken on approximately 1/3 of its membership from the Department for Medicaid Services (DMS) on a quarterly basis, which is placed in our FACETS system. Members' language data is also supplemented and updated in FACETS by the Plan's Member Services department. This information is then extracted from FACETS and reported as listed below. The Plan also identifies providers' language spoken through the credentialing process.

Grievances filed by Attitude and Service by Race/Language

Race/Language	Number of Members	Percentage
White	19	82%
Black	2	9%
Unknown	2	9%

1

Analysis of Complaint Data Submitted

Passport submitted two files with member complaint data in Excel files to aid in our analysis. Below we provide a summary of the information included in those files.

Table 1D-1: Member Complaints, April 1, 2010 through June 30, 2010

Complaint Period	Complaint Category	Count of Complaints Received	Percentage
04/01 - 06/30/2010	TPL - Pharmacy	57	14.0%
04/01 - 06/30/2010	Denial/Reduction of Services	102	25.1%
04/01 - 06/30/2010	Office Staff Unprofessional	7	1.7%
04/01 - 06/30/2010	Diagnosis Treatment Slow/Incomplete/Unclear	28	6.9%
04/01 - 06/30/2010	Dissatisfied with Auto Assignment	195	48.0%
04/01 - 06/30/2010	Non Par Provider Billing Member	1	0.2%
04/01 - 06/30/2010	Verbal Abuse	1	0.2%
04/01 - 06/30/2010	ID Card	1	0.2%
04/01 - 06/30/2010	Communication Barrier	1	0.2%
04/01 - 06/30/2010	COB/TPL Medical	6	1.5%
04/01 - 06/30/2010	Other	3	0.7%
04/01 - 06/30/2010	Dissatisfied with Information Provided	1	0.2%
04/01 - 06/30/2010	Inadequate/Inaccurate Dispensing	2	0.5%
04/01 - 06/30/2010	Non-Formulary	1	0.2%
	Total Complaints Received	**406**	100.0%

According to Passport, no complaints were unresolved.

PHP provided DMS with a summary of member complaints for the period April 1, 2010 through June 30, 2010. We noted that this report to DMS included a total of 418 member complaints. We are unable to determine why the amounts reported varied but it may be due to timing issues. The variance was spread across the various categories and ranged from zero to three.

Table 1D-2: Member Complaints, June 2010

Complaint Period	Complaint Category	Count of Complaints Received	Percentage
June 2010	TPL - Pharmacy	14	12.6%
June 2010	Denial/Reduction of Services	24	21.6%
June 2010	Office Staff Unprofessional	1	0.9%
June 2010	Diagnosis Treatment Slow/Incomplete/Unclear	5	4.5%
June 2010	Dissatisfied with Auto Assignment	60	54.1%
June 2010	COB/TPL Medical	6	5.4%
June 2010	Other	1	0.9%
	Total Complaints Received	**111**	100.0%

There was no indication in this file regarding the number of complaints that were resolved.

√ Observations, Findings or Recommendations Related to Provider and Member Complaints and Concerns

1) It appears that provider satisfaction is relatively high based on the low volume of complaints and grievances received in response to our request for those items. However, provider feedback may also be impacted by the unique interrelationships that exist between University Health Care, Inc. (Passport), the Partnership Council, the Board of University Health Care, Inc. and the provider/owners of the health plan.

2) Passport written complaints and grievances policies and procedures appear to be in compliance with applicable federal and state regulations and the provisions of the contract between DMS and Passport. However, our analysis was limited to the requirements of the initiative, which did not include an analysis of every process or requirement within the regulations.

3) There is evidence that Passport's monitoring of and communication with some of its subcontractors was inadequate during the audit window. In particular, Passport did not adequately monitor the escalated dental provider complaints. The contract between MCNA and Passport indicates in section 2.1.2 that "UHC (Passport) shall operate, at its own expense, reasonable quality assurance and utilization review protocols and Member grievance programs (collectively, the "UR/QA Programs)." It would appear this process either was not implemented or was ineffective, resulting in the same provider bringing the same escalated complaint to Passport Health Plan against the then current third party administrator for dental claims. PHP has indicated that it has exercised its right to terminate the contract with MCNA effective 3/21/12 and informed us that they have implemented appropriate contract monitoring strategies.

4) It appears that both third party administrators for dental services may not have been in compliance with the requirement to "stay" recoupments until a complaint is resolved, that PHP has not closely monitored subcontractor appeals, nor has PHP performed effective utilization review/quality assurance programs.

5) There appears to be a significant number of member complaints related to the auto assignment process. Passport staff indicated that when a member is enrolled, if that member fails to select a primary care provider, then the member will be "auto assigned" to a provider based on a number of criteria including previous relationship with that provider, current family member assignments and geographic factors. Passport may want to evaluate the effectiveness of this process based on the number of complaints being received.

OBJECTIVE 1E: BUSINESS RELATIONSHIPS

The key activities related to this task include:

- Review the relationship between the Board Members and Passport and benefits obtained by the facilities that employ those Board members.

General Approach

UHC Board

The analysis of reviewing the relationships between UHC Board Members and Passport and the benefits obtained by the facilities that employ those Board members began with requesting a list of all Board members who held a position during the examination window, as well as their contact information. Using the list provided and various research tools, we attempted to identify any possible business relationships between the Board members and UHC/PHP.

We requested various Board policies regarding how members are selected and terminated, their term on the Board, their responsibilities, mission statements, charter, objectives, conflicts of interest, tenure, subcommittees, and other information. We also requested meeting agendas and meeting minutes from the period January 2008 to the current period. We received the Board meeting minutes and agendas; however, committee and subcommittee minutes, as well as most exhibits, presented to the Board during the meetings were not provided and were not included in the analysis.

We requested a narrative explanation of the relationships between all entities affiliated with PHP and the members of the Board of Directors for University Health Care, Inc, from January 2008 through the then current period. This document was not received until October 10, 2011, and appears incomplete. The document was first requested on September 2, 2011 as part of the baseline data request. The due date of that request was September 8, 2011.

A Board Member Survey, which was to be completed by each of the Board Members, was also prepared and initially sent to selected board members and subsequently sent to all Board members where a valid email address was provided. The survey required members to attest to the accuracy of their responses, including their business relationships, compensation, benefits, roles and responsibilities, gifts and contributions, and other information.

We also requested a list of all subcontractors and vendors that PHP had contracts with from January 2008 through the then current period. We asked that vendors be included where the services provided involved medical services, care coordination, patient management, or that involved care provided to members in any way, including if they contribute to the administration or operation of the health plan. Again, the information provided by the health plan appears to be incomplete. We requested this information in

order to evaluate any relationships which might exist between members of the Board or Partnership Council and the subcontractors and vendors with which UHC conducts business.

The Partnership Council

The analysis of reviewing the Partnership Council (Council) members began with requesting a list of all Council members who held a position during the examination window, as well as their contact information. Additionally, we requested copies of the Partnership Council charter; terms, procedures, mission statements, objectives, education and/or experience requirements; expense reimbursement, per diem reimbursement, gifts, in-kind payment policies, perks, bonuses, compensation, and benefit policies; appointment and termination policies; policies related to conflicts of interest; meeting agendas and meeting minutes from January 2008 to the then current period.

We received most of the Council meeting minutes and agendas. The November 18, 2010 and the December 16, 2010 meeting minutes of the Council were not provided, although agendas for these meetings were provided.

Although a charter for the Partnership Council was not provided, the Articles of Incorporation for "Region 3 Partnership Council" (August 1997) and the "By-Laws of The Region 3 Partnership Council, Inc" were provided along with a mission statement (2007), the Partnership Council Roles and Fiduciary duties and the Council goals established in 2009.

As for the Partnership Council terms and appointments, according to UHC, the Partnership Council members remain on the Partnership Council until they resign and the UHC practice is to elect officers on an annual basis in July. In accordance with the "By-Laws of The Region 3 Partnership Council, Inc" (by-laws), a director may be removed from office, with or without cause, at a meeting called specifically for that purpose, by a vote of a majority of those members present who are entitled to vote for the election of said director. Additionally the by-laws state, "Each director shall serve a term of one (1) year… continuing until their successor has been chosen and has accepted their appointment. Directors shall be eligible for re-appointment without limitation." The by-laws indicate an annual meeting, held in July, is conducted to appoint the board of directors (of the Partnership Council) and to elect officers of the corporation.

Written education and experience requirements were not found for the examination period according to UHC. UHC indicated if a Council position is open, a search by the members is conducted for a person with the appropriate knowledge base, and then the candidate fills out an application. A vote is taken on the candidate (by the Partnership Council). The "Application for The Partnership Council" for 2010 and 2011 was provided and asks for current job position; however, for both 2010 and 2011, the application does not ask for any educational background. It asks the applicant to indicate whether they are applying as a "Consumer/Consumer Advocate" or "Provider".

No (Partnership Council) policy for travel and expense reimbursement was provided. UHC indicated in their response that they did not find a written travel and expense policy in effect for the time period of the examination. Additionally, policies regarding the receipt of gifts, in-kind payments, and perks, were not provided. UHC indicated they were unable to find written policies on these subjects. UHC noted that the Partnership Council members are not paid bonuses and are not compensated for their service on the Partnership Council and do not receive insurance benefits (e.g., life, health, etc.). According to the by-laws, "No director shall receive compensation for services as a director; however, any expense incurred by any director by reason of their duties or responsibilities as such may be paid by the corporation; provided, that nothing contained herein (in the by-laws) shall be construed to preclude any director from serving the corporation in any other capacity and receiving compensation therefore *[sic]*."

A "Conflict of Interest Disclosure Confidentiality Policy Acknowledgement" form was provided. UHC indicated this policy was developed in 2009 and remains in effect.

A Partnership Council Board Member Survey, which was to be completed by each of the Partnership Council members, was also prepared and initially sent to selected Board members, where a valid email address was provided, on January 16, 2012 and January 17, 2012. The survey required members to attest to the accuracy of their responses, including their business relationships, compensation, benefits, roles and responsibilities, gifts and contributions, and other information.

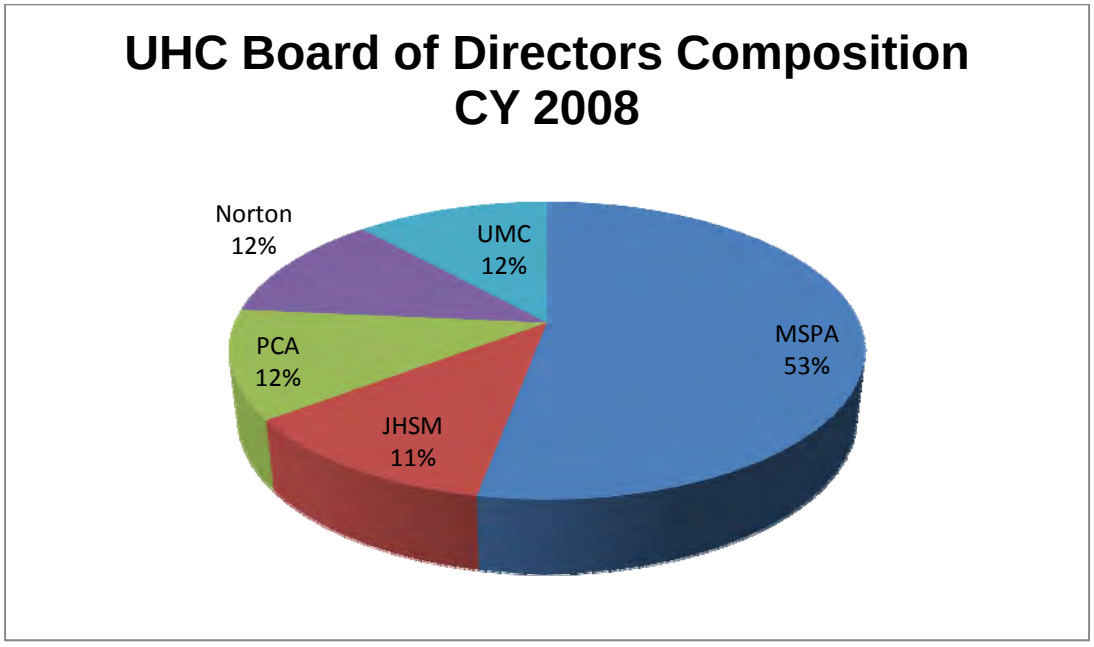
Overview of UHC Board

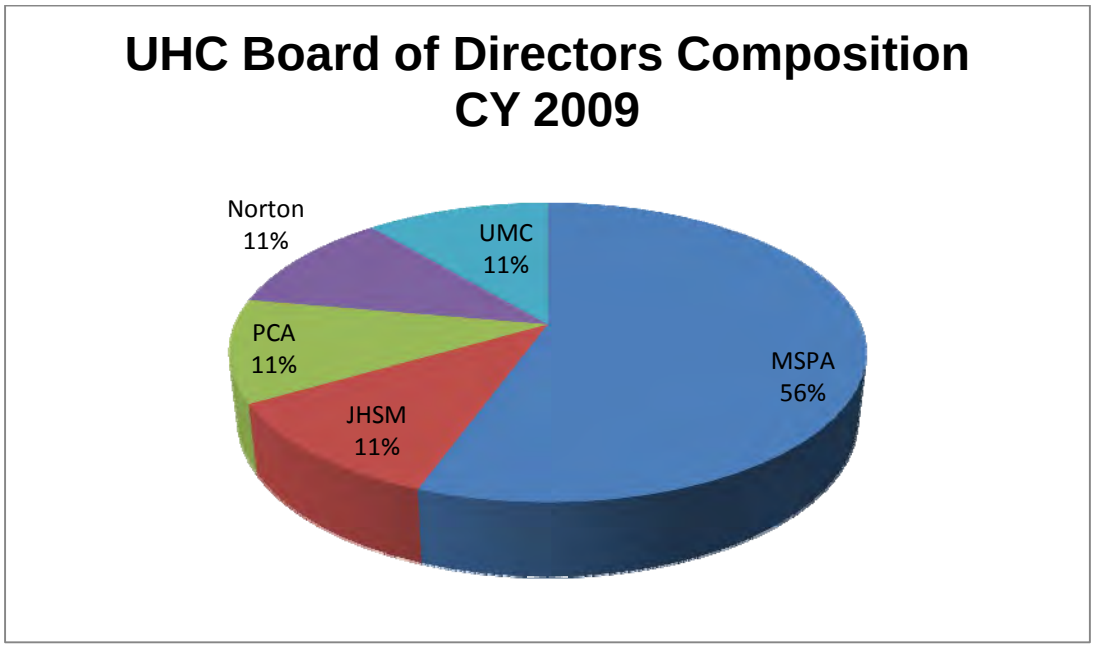
Board minutes provided were fairly detailed until the middle of 2010. According to statements made by Mark Carter during an interview on September 12, 2011, the Board decided in the middle of 2010 to provide less detail in the Board minutes. Based on the Board minutes provided, it appears that until 2011, the UHC Board of Directors met quarterly, unless special board meetings were required. Committees appeared to meet in the interim. In 2011, the UHC Board of Directors met monthly through June 2011.

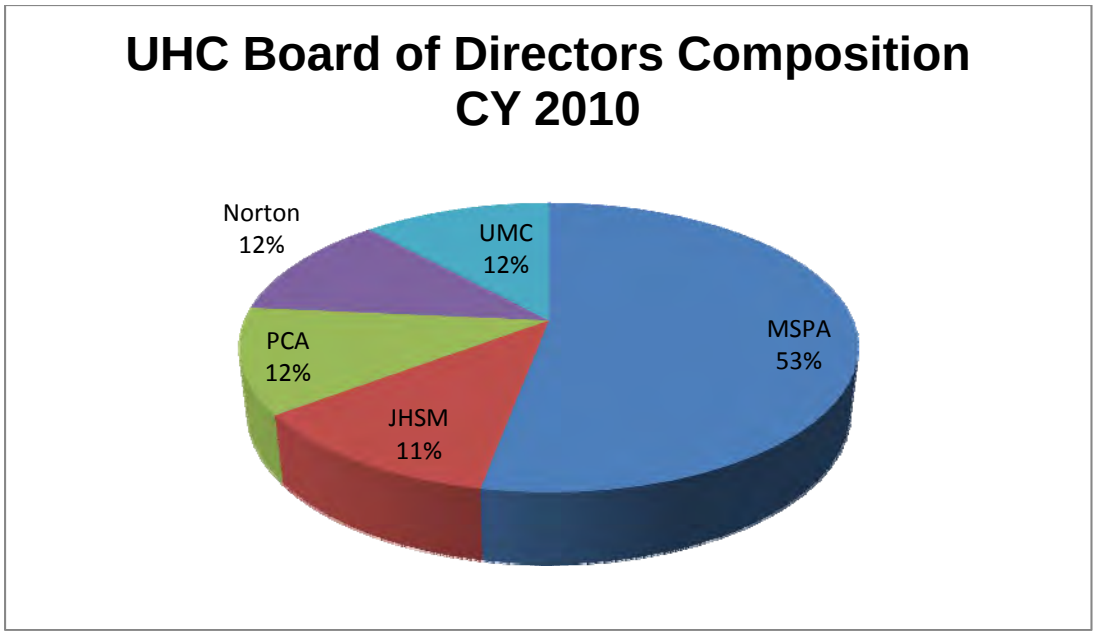
During our analysis of UHC Board minutes, we noted several Board members frequently attended scheduled meetings, as well as, personnel from UHC, AMHP, and other stakeholders or interested observers. During the examination window, the UHC Board of Directors was primarily made up of 16 to 18 members, representing the following five organizations:

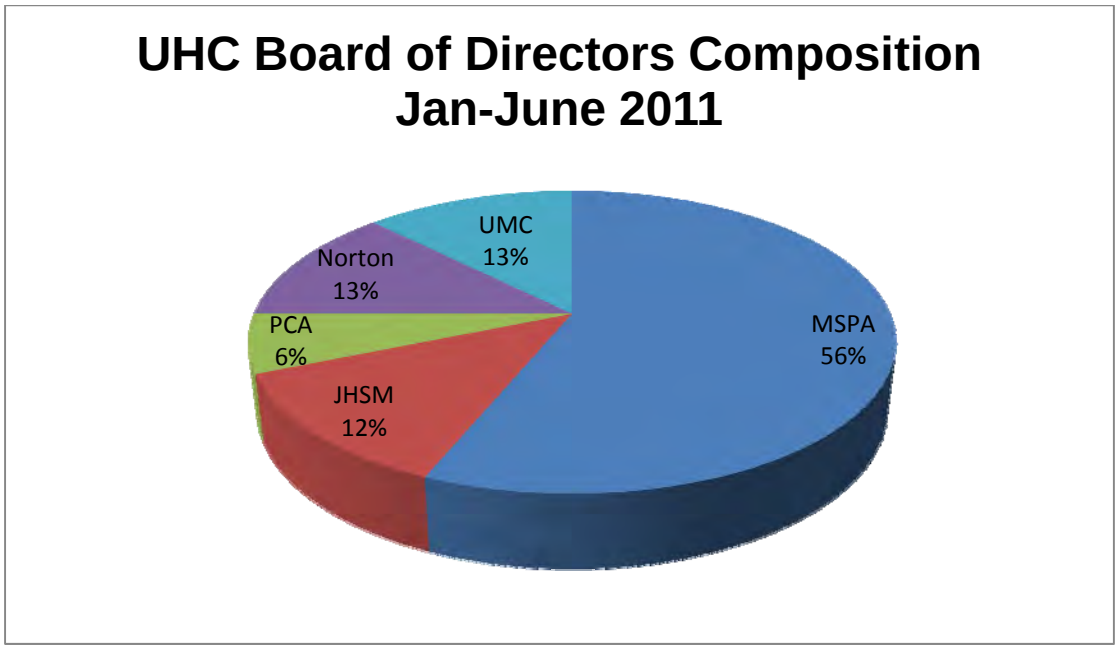
- University of Louisville Medical School Practice Association (MSPA, a.k.a. University Physicians Associates)
- University Medical Center (UMC) d/b/a University of Louisville Hospital
- Jewish Hospital and St. Mary's Healthcare (JHSM)
- Norton Healthcare - Alliant Health System
- Louisville/Jefferson County Primary Care Association (PCA)

Based on the member agreement dated May 21, 1998, as well as, a list of Board members and the organization they represent, the Board appears to be made up proportionately to the initial UHC/Passport capital contributions made by each organization. The following graphs show the composition of the UHC Board of Directors by the organizations they represent. The percentage of representation does not necessarily reflect the sponsoring organization's ownership interest due to vacancies, etc.









It was noted in the March 16, 2011 Board minutes, a "Proposed Staggered Board Structure" document was presented and approved. This structure indicated the initial Board (beginning July 1, 2011) would be composed of 15 members: five from the MSPA; one each from UMC, JHSM, Norton, and PCA; and three each from the Partnership Council and the community at large. Although the number of representatives from the sponsoring organizations was reduced, the proportion among the sponsoring organizations remained substantially the same. The August 2011 Board meeting minutes indicated that the Board was reduced and three additional Board member positions representing the Partnership Council were in attendance.

UHC indicated that there were no clearly defined terms for Board members during the examination window. However, terms were established beginning July 1, 2011 and after. The March 2011 Board minutes indicate the approval of the Board member term policy: "The initial 15 Board members as of July 1, 2011 will serve for 3 years. Then starting July 1, 2014, 3 of the initial Board members will be replaced. Their successors will serve 5 year terms. Each year, 3 Board members will be replaced."

The positions on the Board include: Chairman, Vice Chairman, Second Vice Chairman, Treasurer, Secretary, Ex-Officio, and Board Member. Committees and subcommittees appear to be comprised of Board members and UHC executives. The following committees and subcommittees have served in some capacity over the period of the examination window:

Board Committees:

- Executive Committee
- Finance Committee
    - Subcommittee: Passport Advantage (PAD) Workteam
- Compliance Committee
- Audit Committee
- Nominating and Governance Effectiveness Committee

Partnership Council:

- Primary Care Physician Workgroup
- Quality Medical Management Committee (QMMC)
- Delegation Oversight Committee (DOC)
- Quality Member Access Committee (QMAC)

The Audit Committee was formed in February 2011 and the Nominating and Governance Effectiveness Committee was formed in May 2011. UHC stated, "The Nominating and Governance Effectiveness Committee shall consist of a minimum of three (3) Board members. The Chairman of the Board shall appoint one of the members of the Committee as its Chair. The Committee shall meet at least quarterly, or more frequently as circumstances may dictate. A majority of members of the Committee shall constitute a quorum for any meeting. The Committee shall assure that each Board member annually completes a Conflict of Interest Disclosure form."

During the Partnership Council meeting on March 15, 2011, the minutes indicated that the meeting summary to the March 10, 2011 Governance Workgroup was discussed and stated "The (Governance) workgroup felt that 11 of 15 voting members would be appropriate to constitute a quorum."

Overview of the Partnership Council Board

According to the document "Partnership Council – Overview, Mtg Frequency, Oversite Accountability, Scope, Composition, 2008", the Partnership Council has responsibility for reviewing, providing feedback, and approving the annual QI (Quality Improvement) and UM (Utilization Management) Program Descriptions, the QI Work Plan twice

annually, and the annual QI and UM Evaluations. The Partnership Council has ongoing responsibility for recommending policy decisions, reviewing and evaluating the results of quality activities, instituting actions and overseeing follow up as appropriate.

The "PC Role, 2009" document contained an explanation of the Partnership Council Role and Fiduciary Duties, including "the Partnership's actions must be approved by UHC – because UHC bears all fiduciary, regulatory, and contractual responsibility for the program – substantial responsibility has been delegated to this body." Additionally, the UHC Board, according to the "PC Role, 2009" document, has delegated the following responsibilities and fiduciary duties to the Council:

1) Maintain a Board of Directors composition representative of the Partnership's health care providers, including representatives of Medicaid recipients;
2) Jointly evaluate the performance of the administrator hired by UHC;
3) Acting through its Medical Management Committee, establish policies and guidelines regarding quality issues, including:
    a. Quality assurance guidelines;
    b. Utilization management policies;
    c. Standards and rules of participation for providers (including risk options);
    d. Contract structure for generic contracting units;
    e. Structure of provider compensation arrangements to ensure compliance with government guidelines; and
    f. Medical and medically related services to be purchased by the Partnership and methods for selection of qualified providers of such services.
4) Establish and maintain:
    a. Medical Management Committee;
    b. Quality and Access Recipient Advisory Committee – composed of public health representatives and Medicaid recipients and advocates (as necessary) to meet the State requirements;
    c. Grievance Subcommittee;
    d. Quality and Utilization Management Subcommittee;
    e. Provider Advisory Committees;
    f. Executive Committee;
    g. Any other committees the Partnership deems necessary to administer the Council.
5) Review, provide feedback, and approve the annual Quality Improvement (QI) and Utilization Management (UM) Program Descriptions, the QI Work Plan bi-annually, and the annual QI and UM Evaluation documents.
6) Recommendation of centralized services to be purchased on a system-wide basis (currently Pharmacy, Dental, Vision, and Transportation) and the selection of the benefit managers for these services.

In regards to a quorum, per the Partnership Council July 20, 2010 minutes, "Mr. Schoenbacchler noted during the last meeting, there was a brief mention of what constituted a quorum for committees of the Council. He noted the two committees reporting some of the most meaningful information to the Council are the Quality

Medical Management Committee (QMMC) and the Quality Member Access Committee (QMAC). Both committees have consented that five (5) members constitute a quorum, with only a majority vote needed to send recommendations to the Council. After further discussion, Mr. Schoenbaechler suggested the Council consider the following questions:

1) How many participants should be present at the committee meeting for an appropriate operational quorum in order to ensure the issue has been meaningfully and sufficiently discussed? and
2) Would a simple majority vote of the quorum be appropriate for making and sending recommendations to the Council?

The Partnership Council February 15, 2011 meeting minutes stated, "A consensus was reached by the Council that the preferred approach would be the direct appointment of Council members to the Board." The positions that can be held on the Partnership Council include: Chairman, Vice Chairman, Secretary, and Partnership Council Member.

According to the Partnership Council July 19, 2011 minutes:

> (13) (B) Election of UHC Representatives. At the annual meeting, the Partnership Council Board of Directors shall elect one of its members as Board Chair. The Board Chair shall, by virtue of that office, be one of the three Council representatives to the UHC board of directors. Nominations shall then be taken for the second UHC representative position, recognizing that given the election of the first UHC representative, all nominees must meet the demographic requirements for service set forth in Section 13(A) above (in minutes). Following the election of the second UHC representative, nominations shall be taken for the third UHC representative position, recognizing that, given the election of the first and second UHC representatives, all nominees must meet the demographic requirements for service set forth in Section 13 (A) above (in minutes).
>
> C) Method of Election. In all elections, the Partnership Council Board of Directors may take nominations—from the Nominating Committee, the floor, or both – for all elected positions, including director, officer, or UHC representative. In any election, the person receiving the highest number of votes shall be chosen, provided that such person received a majority of the votes cast. If not, there shall be a subsequent vote (s) considering only those nominees receiving the two highest number of votes cast. In the event of a tie vote, additional votes shall be taken until one nominee receives a majority of the votes cast.

According to the document titled "Partnership Council – Overview, Mtg Frequency, Oversite Accountability, Scope, Composition, 2008", the Partnership Council meeting frequency was every two months and must meet at least five times during the year to

achieve the QI Program objectives. Based on the Partnership Council Board meeting minutes provided for the period July 2008 through July 2011, it appears the Partnership Council board met approximately every two months until 2011. In 2011, the Partnership Council met monthly from January through July, with exception of the month of April (no meeting was held in April). Therefore, it appears QI Program objectives for meeting frequency were met.

The "PSC Application" indicated "Participation on the Partnership Council involves attending at least seven meetings *[sic]* per year. Meetings are generally two hours, held during the evening (beginning at 6:00 pm) and dinner is included." It is not clear what constitutes seven meetings. In 2010, meeting minutes were provided for only five Partnership Council meetings; however, agendas for seven Partnership Council meetings were provided. The meeting minutes for November and December 2010 meetings were not provided.

According to the Council by-laws, "10 members of the Board of Directors (council) shall constitute a quorum for the transaction of business at any meeting of the Board of Directors, provided that if less than a quorum, of the directors are present at said meeting, a majority of the directors present may adjourn the meeting from time to time without further notice." On January 17, 2012, Jerry Deom, chairman of the Partnership Council indicated that (typically) the attorney will determine if a quorum is present and if not, will adjourn the meeting.

Committees, as well as subcommittees, meet in the interim and the Partnership Council reports to the UHC/Passport Board on a quarterly basis. The Partnership Council meeting minutes and by-laws reference the following committees of the Partnership Council:

- Quality Medical Management Committee (QMMC). The by-laws directs that the QMMC is to recommend to the Board of Directors policies and guidelines regarding quality issues, including quality assurance guidelines; utilization management policies; standards and rules of participation for providers (including risk options); contract structure for generic contracting units; structure of provider compensation arrangements to ensure compliance with government guidelines; and medical and medically related services to be purchased by the Partnership and methods of selection of qualified providers of such services. This committee appears to meet monthly and included the following subcommittees:
    - Administrative Benefits and Appeals Committee
    - Credentialing Committee
    - Organizational Provider Credentialing Committee
    - Pharmacy & Therapeutics Committee
    - Behavioral Health Pharmacy & Therapeutics Committee
    - Child & Adolescent Health Committee
    - Passport Advantage Committee
    - Passport Health Plan Delegation Oversight Committee
    - Passport Advantage Delegation Oversight Committee

    - Medical Criteria/Policy Review Committee
    - Quality of Service Committee
    - Women's Health Committee
    - Health Outcomes Oversight Committee
    - Behavioral Health Committee
    - Internal Quality Review Committee
- Quality Member Access Committee (QMAC). The by-laws stated that the QMAC is to be comprised of public health and Medicaid recipients and advocates to review and make recommendations concerning: Medicaid and partnership policies affecting members; quality improvement of and access to services; and grievance and appeals processes.
- Nominating Committee. This committee was added in March 2011. According to the March 15, 2011 meeting minutes, "The nominating committee will include a 3 person committee, appointed by the chair, who will review current membership, vacancies and additional duties imposed by the Governance Committee. Mr. Deom appointed; Linda Sims, Dr. Kenneth Zegart and Jim Bill for positions on the nominating committee." The three named members appointed were approved unanimously by the Partnership Council members present.
- Additionally, the Partnership Council appears to have the following workgroups:
    - Primary Care Physician (PCP) Workgroup
    - Governance Workgroup
- The Rural Health Advisory Council was approved in the July 21, 2009 meeting minutes to be an "ad hoc" council and to meet "as needed". This committee, according to the Partnership Council minutes, assisted rural health practitioners in resolving issues specific to their practices. The committee provided recommendations to management and to enhance quality care and access in rural communities.

The November 11, 2008 meeting minutes indicated that the Delegation Oversight Committee "is responsible for oversight of the Plan's delegated (sub) contracts. It is comprised of Plan staff and representatives from the delegated entities. Prior to each meeting, each delegate submits required data and reports for review and analysis by the Plan. The information is summarized and discussed at the Delegation Oversight Committee meetings. Meetings are held quarterly with follow up meetings scheduled one month after the quarterly meeting." Additionally, the Delegation Oversight Committee was noted in the Partnership Council meeting minutes as being responsible "for monitoring and evaluating all subcontractors to which utilization and/or quality management, credentialing, member services, provider services, and/or claims operations functions have been delegated."

With exception of the Internal Quality Review Committee, reports from the above committees were documented in the Partnership Council meeting minutes.

The Partnership Council meeting minutes included indications that several council members frequently attended scheduled meetings, as well as UHC staff, Passport Health Plan staff, legal staff, and other stakeholders or interested observers. During the

examination window, the Partnership Council was primarily made up of 17 to 28 members, representing several organizations and associations. Based on the Partnership Council meeting minutes provided for January 2008 through July 2011, no less than 10 members were in attendance at any given meeting. The average number of Partnership Council members in attendance, including legal counsel, was as follows:

Calendar Year	Average Number of Partnership Council Members Present
2008	13.8
2009	14.7
2010	16.2
2011 (through July)	17.0

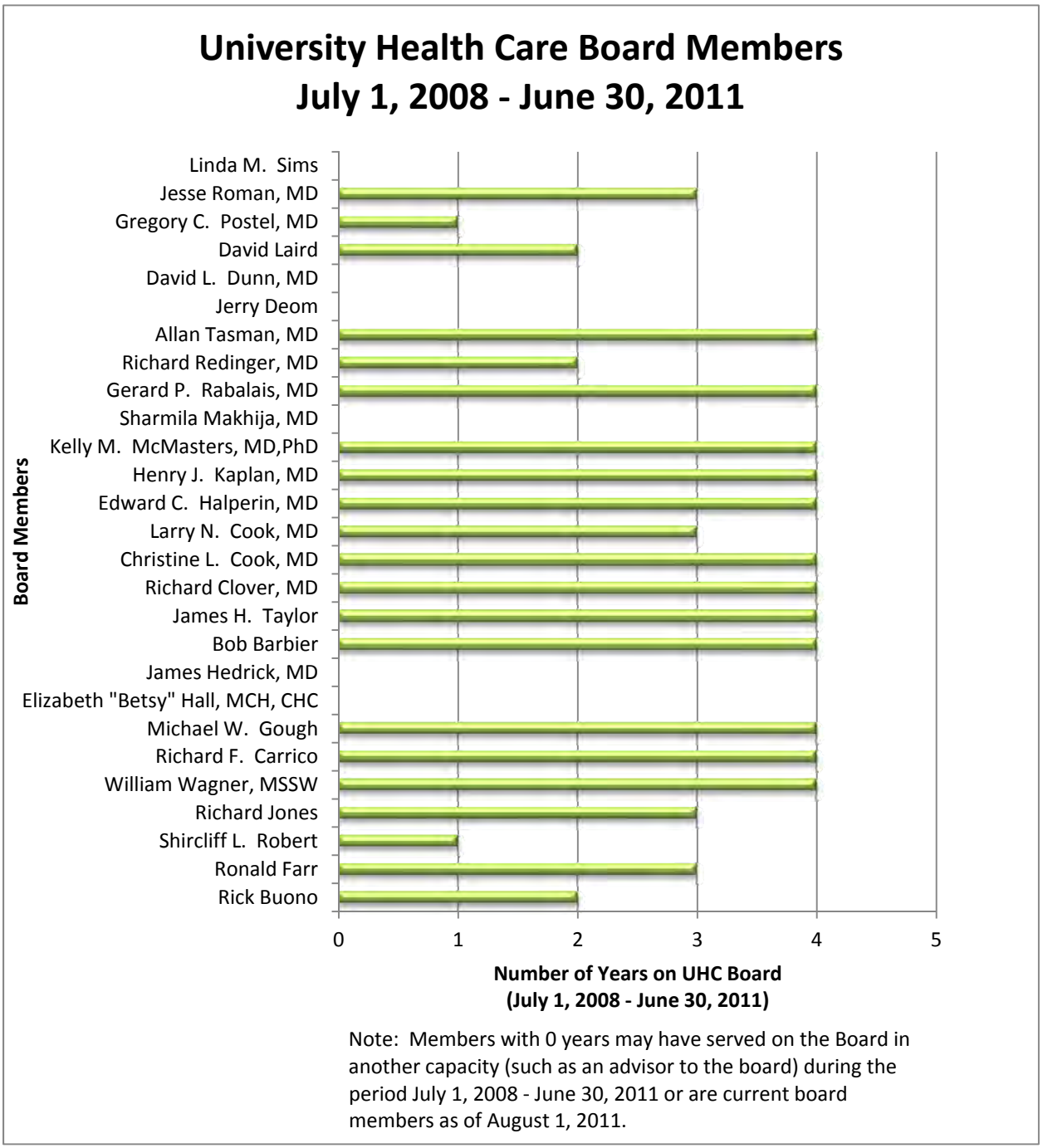
The following table shows the composition of the Partnership Council by the organizations/association represented. We noted that, with the exception of the University of Louisville and the UofL Medical School Practice Association with two representatives each, if an organization was represented on the Council, the representation consisted of one individual prior to January 2011. Beginning January 2011, Park DuValle Community Health Center and Hardin Memorial each had two individuals on the Council as well.

Partnership Council Entity	2008	2009	2010	Jan-June 2011
Bowersox Vision Center	0	1	1	1
Seven Counties Services	1	1	1	1
University Hospital	0	1	1	1
Gentiva Health Services	0	0	1	0
Deom Health Enterprises	1	1	1	1
University of Louisville	1	2	2	2
Gaines & Associates	0	0	0	1
Precision Healthcare Delivery	1	1	1	1
Falls City Medical Society	1	1	1	1
Physicians to Children & Adolescents	1	1	1	1
Park DuValle Community Health Center	0	0	0	2
Louisville Metro Dept. of Public Health & Wellness	1	1	1	1
Hardin Memorial Hospital	1	1	1	2
Kosair Children's Hospital & Pediatric Services	0	1	1	1
Masonic Homes of Kentucky	0	1	1	1
Louisville Metro EMS	0	1	1	1
Elizabethtown Physicians for Women	0	1	1	1
Baptist Hospital East	0	1	1	1

Partnership Council Entity	2008	2009	2010	Jan-June 2011
Home of the Innocents	0	1	1	1
Louisville Dental Society	0	1	1	1
Hall Render Killian Heath & Lyman PSC	0	1	1	1
Lincoln Trail District Health Department	1	1	1	1
Consumer Advocate Children and Family Related Representative	1	1	1	1
Consumer Advocate Aged Representative	1	1	1	1
Greater Louisville Medical Society	1	1	1	1
Louisville Primary Care Association-FQHCs	1	1	1	0
UofL Medical School Practice Association	2	1	1	1
University Med Center	1	0	0	0
Unknown	1	0	0	0
Louisville Transportation Company	0	1	0	0
Visiting Nurse Association/JHHS	0	1	0	0
Total Number of Members	**17**	**27**	**26**	**28**

Overview of Passport Board Members

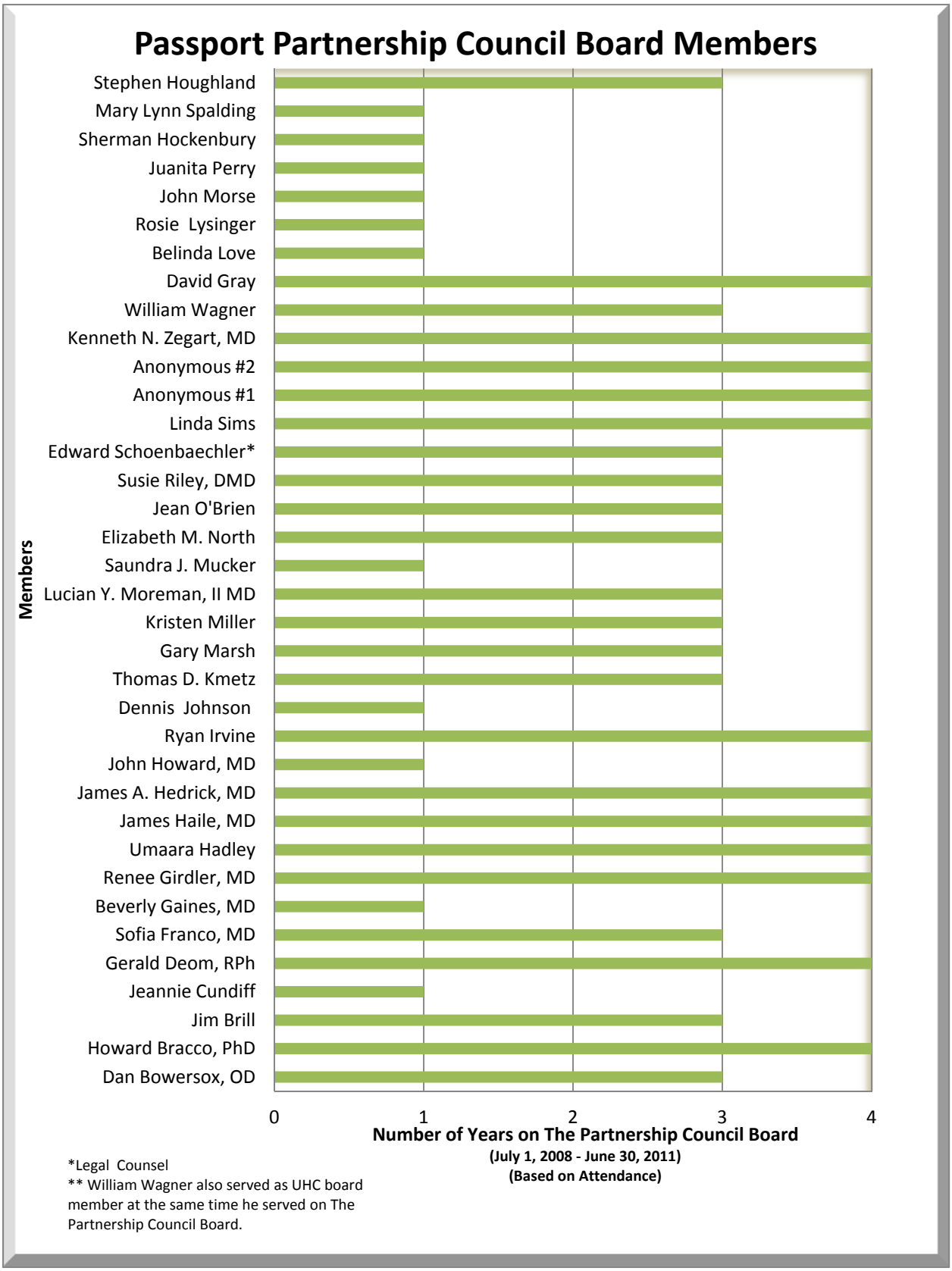
During the period from July 1, 2008 through August 2011, the board consisted of 27 different members and was primarily comprised of the Chief Executive Officers (CEOs), Chief Financial Officers, vice presidents, professors and/or chairmen, from the five sponsoring organizations. The following graph includes the number of years each UHC Board member served on the Board during the examination window, July 1, 2008 through June 30, 2011. This graph also includes Board members who may have served on the Board for the period under examination, but either served in another capacity (such as an advisor to the Board) or is serving as a then current Board member as of August 1, 2011.



In addition to the sponsoring organization by which the Board member is employed, Board members may also have several affiliations with outside organizations. In some cases, UHC Board members appear to be a Board member, director, and/or business owner of an outside organization.

Overview of the Partnership Council Board Members

During the period from July 1, 2008 through June 30, 2011, the Partnership Council, based on attendance, consisted on average from 12 to 17 members. The Council was made up of members from various areas of the health community, including hospital, health departments, home health, and hospice. The following graph includes the number of years each council member served on the Partnership Council Board during the examination window.



Potential Conflicts of Information

Using the information available, we performed an information analysis, including an evaluation of the Passport Vendor Payment List provided by PHP. We compared this information to the list of Board member affiliations and various forms of readily available information. Based on this high level assessment, we did not identify any apparent concerns or relationships that would necessitate additional research. However, as indicated previously, much of the data or documentation requested was not received or it was incomplete. Additionally, the alternative information that we have used may not provide an accurate reflection of true relationships among parties.

Interviews were conducted with three Board members and two partnership council members and surveys were sent to both Board members and partnership council members where a valid email address was provided by Passport. Through these interviews and survey responses, no specific conflicts of interest were identified; however, during one interview it was noted that there existed the potential for the University of Louisville to influence decisions of Board matters as a result of majority voting rights. MSPA and UMC combined represented approximately 65 percent of the UHC Board members during the examination period. After the Board restructuring in July 2011, MSPA and UMC combined Board positions represent 40 percent of the UHC Board. Depending on Board attendance, the University of Louisville could still potentially represent majority voting rights and possibly exert significant influence during the Board's decision-making process.

Upon review of the Board meeting minutes, it appears conflict of interest forms are executed annually. During the January 2012 UHC Board meeting, the conflict of interest, included in Exhibit D to this report, was read at the beginning of the meeting. During this meeting, it was mentioned that this was the first time the conflict of interest was read aloud during the meeting. During the Board member interviews, one member indicated he did not recall conflict of interest discussions in the past; however, another member indicated "it's not the first time the subject (conflict of interest) has come up but it is most likely the first time it was read." This member indicated he was not aware of any conflict of interest between AmeriHealth Mercy and Passport. He also indicated that the Board has strict rules that the Board is not to have involvement in rate setting to avoid conflict of interest. Rate setting, according to this member, was never to be done at the Board level, however, exceptions were charity care and ownership return of capital. Another member also noted that the conflict of interest statements were executed annually. When asked if this member recalled any specific conflict of interest during his time on the Board, he indicated that by the very nature of the organization, he believed there will always be a potential for conflicts of interest. He did not recall any significant conflict of interest discussions related to individual actions. He felt provider members deal with this (conflict of interest) appropriately and the provider network is generally "OK" with the rates.

Policies of the Board

As indicated by UHC, relatively few board policies were in existence during the audit window, July 1, 2008 through June 30, 2011. Several policies were developed and approved by the board during 2011. The table below outlines the policies that appear to be available over the course of the examination window.

Policy	Policy Appears to Have Been Available	Effective
Charter	Not Identified	
Mission Statement	√	1999
Member Agreement	√	1999
Terms	Not Identified	
Expense Reimbursement	Not Identified	
Travel	Not Identified	
Gifts	√	May 2011
In-Kind Payments	Not Identified	
Perks	Not Identified	
Bonuses	Not Identified	
Compensation	Not Identified	
Appointments	Not Identified	
Terminations	Not Identified	
Conflicts of Interest	√	See Below
Code of Conduct	√	May 2011
Donations and Sponsorship	√	June 2011

Although UHC indicates policies surrounding gifts and gratuities were not documented, UHC provided a document titled "UHC'S Code of Conduct". In this document, the following policies were identified: Ethical Responsibilities of UHC, Compliance with the Law, Conflict of Interest Policy, Gifts, Gratuities, and Kickbacks, Confidentiality of Information, Maintenance and Accuracy of Records, Work Environment, Cooperating with the Government, and Non-Retaliation. It was unclear, based on UHC's response and the file name as to whether these policies were in effect during the review period. UHC stated on February 13, 2012, "…we are unable to determine when the UHC Code of Conduct was drafted or for what time period it was effective. Our understanding of UHC management's practice, based on notations in Board minutes during the time period of the audit, is that this Code of Conduct was effective during the time period of the audit. Note: Our records show that a copy of the Code of Conduct was given to the auditors for the APA audit."

Although the travel expense policy implemented in August 2011 included a requirement for UHC to review the vice president's and CEO's travel expenses on a quarterly basis, there did not appear to have been a travel expense policy in effect during the examination window and there did not appear to have been any expense limits or thresholds established that would have required prior approval by the Board.

Terms for Board members were not in place during the examination window; however, terms have since been established whereas Board members rotate off the UHC Board every three to five years. Also, the UHC Board elects officers on an annual basis every December.

Board Member Survey Results

A Passport Health Plan Board Member Survey was developed to capture information regarding the Board of Directors, including the identification of the positions held, attendance records, subcommittees, Board compensation (monetary and non-monetary), benefits received by the Board member's organization, and the identification of any relationships between the Board member and Passport Health Plan, AmeriHealth Mercy, or any subcontractors, related parties or venders.

The Passport Health Plan Board Member Survey was sent on October 21, 2011 to a sample of four Board members who were selected for possible interviews. Only one survey was returned initially. Surveys were sent again on November 28, 2011, to all Board members with valid email addresses. A total of 24 surveys were sent. Of the 24 surveys, a response of no involvement (i.e. appointment to the Board after the examination period or no voting rights during the examination period) was returned for six Board members. Of the remaining 18 surveys, surveys were returned from 11 members and seven members did not return the survey. Of the seven members where no survey was returned, five members were representing University of Louisville Medical School Practice Association during their tenure on the Board.

Below are the responses to *Survey Question #4 Approximately how many Board meetings have you/did you attend?*

Board Member Attendance					
Board Member	**Organization[6]**	**Year**	**Total # of Board Meetings**	**# Attended In Person**	**# Attended by Phone/Internet**
Gough	Norton	2008	11	9	0
Wagner	FHC	2008	4	4	0
Taylor	UMC	2008	4	3	0
Barbier	UMC	2008	4	2	0
Cook, L	UofL	2008	4	4	0
Clover	UofL	2008	4	3	0
Cook, C	UofL	2008	2	1	0
Rabalais	UofL	2008	4	4	0
Farr	Jewish	2009	8	8	0

[6] The member's organization is that organization the member represented at the time the member served on the Board/Partnership Council and is not necessarily the member's current organization.

Board Member Attendance					
Board Member	Organization[6]	Year	Total # of Board Meetings	# Attended In Person	# Attended by Phone/Internet
Gough	Norton	2009	11	9	0
Wagner	FHC	2009	4	3	0
Taylor	UMC	2009	4	4	0
Barbier	UMC	2009	4	2	0
Cook, L	UofL	2009	4	4	0
Clover	UofL	2009	4	3	0
Cook, C	UofL	2009	4	4	0
Rabalais	UofL	2009	4	4	0
Farr	Jewish	2010	8	8	0
Gough	Norton	2010	11	9	0
Wagner	FHC	2010	4	4	0
Taylor	UMC	2010	4	3	0
Barbier	UMC	2010	4	4	0
Cook, L	UofL	2010	4	4	0
Clover	UofL	2010	4	2	0
Cook, C	UofL	2010	4	4	0
Rabalais	UofL	2010	4	4	0
Farr	Jewish	2011	4	4	0
Gough	Norton	2011	11	9	0
Wagner	FHC	2011	12	12	0
Taylor	UMC	2011	12	7	1
Barbier	UMC	2011	7	7	0
Cook, L	UofL	2011	0	0	0
Clover	UofL	2011	7	0	1
Cook, C	UofL	2011	6	0	0
Rabalais	UofL	2011	12	8	2
Postel	UofL	2011	11	10	0

Through analysis of the Board member survey responses, members responded that a quorum was required for voting decisions and most members referred to what appears to be the more current bylaws: "Third Amended and Restated Bylaws of University Health Care, Inc." Article IV Directors, section 9 "Quorum and Manner of Acting". This section of the bylaws is noted below:

> Eleven (11) of fifteen (15) directors appointed by the Initial Members and the Partnership Council (provided that directors representing at least three (3) Members are present) and entitled to vote shall constitute a quorum for the transaction of business at any meeting of the Board of Directors, provided, if less than eleven (11) of fifteen (15) directors entitled to vote are present (or less than three (3) Members are represented) at said

> meeting, a majority of the directors present may adjourn the meeting from time to time without further notice. The act of seventy-five percent (75%) of the directors present at a meeting at which a quorum is present and entitled to vote on certain matter, shall be the act of the Board of Directors in regard to such matter, unless otherwise required by the Articles of Incorporation or these Bylaws.

Another member submitted an excerpt of the bylaws that read as follows:

> (7) Quorum and Manner of Acting. A majority of the number of directors fixed by these Bylaws (provided that directors representing at least three (3) Members are present) and entitled to vote shall constitute a quorum for the transaction of business at any meeting of the Board of Directors, provided, if less than a majority of the directors entitled to vote are present (or less than three (3) Members are represented) at said meeting, a majority of the directors present may adjourn the meeting from time to time without further notice. The act of seventy-five percent (75%) of the directors present at a meeting at which a quorum is present and entitled to vote on certain matter, shall be the act of the Board of Directors in regard to such matter, unless otherwise required by the Articles of Incorporation or these Bylaws.

The latter excerpt may have been in place during the examination period, where as the first excerpt appears to be from the bylaws amended on August 3, 2011, after the restructuring of the Board. None of the documents provided by the Board members reference an effective date of the bylaws.

Regarding nominations to the Board, members either responded that their sponsoring organization nominated him/her for the Board or the member did not recall who nominated him/her. One member interviewed indicated the Board position came with their position at their organization. A few members responded with an excerpt from the bylaws containing Article III Members (5. Annual Meetings), IV Directors (6. Annual and Regular Meetings), and V Officers (2. Election and Term of Office); however, this did not provide the governance of the election of board members to the UHC Board.

All Board members responding to the survey indicated that they did not receive any compensation, bonuses, reimbursement of travel expenses, or reimbursement of other expenses for serving on the Board. Several members indicated the receipt of Christmas gifts in 2008 and 2009, which included a bottle of wine, edible arrangement, gift certificates, box of candy, and/or a holiday card. No gift (in total) was valued more than $120 in 2008 and no more than $10 in 2009. Although seven surveys were not received, PHP stated that the gifts (noted as received from UHC/Passport) were given to all Board members. Two MSPA members responded no gifts were received. Additionally, a Board member from Family Health Centers, Inc., who only served in an ex-officio (no voting rights) position on the board, also indicated receiving similar gifts. Both members from Norton Healthcare and Jewish Hospital and St. Mary's Healthcare

indicated they did not receive any gifts during the examination period. Additionally, no member returning the survey indicated receiving gifts in 2010 or 2011.

When asked if the Board member or their family member was enrolled as a Kentucky Medicaid or Passport Health Plan medical service provider, two members responded they were and indicated their specialty was radiology/radiology oncology. One member responded they are a pediatric infectious disease physician and provide services approximately four weeks per year at Kosair Children's Hospital. All three members indicated they did not receive any benefits for their practice as a result of their membership on the Board.

When asked if the Board member or their family member have any other businesses that conducted business, sold products, or performed service with Kentucky Medicaid or Passport Health Plan, the members responded "no", with exception of two Board members who responded "UMC, Inc is a provider in the PHP network".

When asked if the hospital the Board member is affiliated with or employed by received any benefits (directly or indirectly) as a result of the Board member's position on the Board, six of the 11 surveys included the following identical response:

> During the period under audit, as noted by the Auditor of Public Accounts in her November 2010 report, my institution received three separate payments in the form of a return of original capital and indigent care grants. Such grants were made for the purpose of assisting our organization with unreimbursed costs associated with Medicaid and uninsured patient. During July 2011 we agreed to repay such funds/such funds were repaid to Passport in connection with a settlement agreement with the Kentucky Attorney General.

Of the remaining five members, four answered "no" or "NA". One member responded that their employer, University of Louisville, was not a hospital and "was not a direct or indirect recipient of any distributions from Passport, however the University did receive two indigent care grants which it passed along in full to MSPA". This member also noted "The University did receive a repayment of a grant it had given MSPA from MSPA, which it subsequently returned to MSPA when MSPA agreed to return monies to Passport."

Board Member Interviews

We selected four Board members for interviews. Two interviews were conducted by conference call on January 20, 2012; another was conducted by conference call on January 23, 2012. We were unable to schedule the fourth interview due to scheduling conflicts. Additional interviews were conducted with other Board members as a result of their positions in one of the sponsoring organizations; however, the information gathered during those interviews is discussed elsewhere in this report.

All three interviewees were employed by their current organization during the examination period. The members have been with their organization from a range of three years to 15 ½ years. One member indicated the Board position came with their employment position and he started on the Board shortly after being hired by his organization. Another member indicated he took the Board position of the prior CEO once that member retired.

Board members were also asked to provide more details regarding the activities of the Board by describing how agenda items are brought to the Board, how the Board operates (overall), and what the Board member's responsibilities were or are on the Board. The comments from these interviewees are summarized below.

The Executive Committee met monthly and prepared the agenda for the Board meetings. The frequency of these meetings fluctuated from monthly to quarterly. One Board member interviewed indicated that the Executive Committee no longer exists. In the past, typically, the Chair and Vice-Chair of the Board met with Passport Senior staff to prepare the Board session. During the committee sessions, the committees would formulate recommendations to be presented to the Board.

One interviewee indicated it is the role of (Passport) management to identify items that should be presented to the Committees. The interviewee noted discussions would be held with Passport's senior management and through these discussions, the committee chair or senior (executive) would decide what items needed to be brought to the attention of the committee and presented for the agenda. Such items could include management compensation, budget, yearly conflicts of interest and other issues that might arise. Recently, the Board discussions have included the topic of charters and discussions regarding the appropriate roles and responsibilities of each committee.

Also noted by one board member, in the past, the University of Louisville representatives exercised significant decision-making influence on the Board and the executive vice president of Health Affairs (of the University of Louisville) was the Board Chairman. This Board member indicated the Board Chair influences what items came before the board.

One member described his role on the Board as receiving notice of the meeting, reviewing the agenda and attending the meeting. His responsibility was to attend the Board meetings and participate on the Board. He also confirmed the subject matter on the agenda is what is discussed, the minutes are appropriate, and the subjects on the agenda were the ones that were presented.

When commenting on the administrative findings of the prior audit, the Board member noted they (the Board) did not know about the travel. He admitted they looked at the income statements, but did not really notice the (travel) expenses and would have most likely considered it a "rounding error". He noted the audit brought to light what kind of things management was not doing. The member went on to say that now the Board has become more micro-managed.

The member indicated rate increases went through the Finance Committee, but the Board never set rates or saw what providers were being paid. The Board member indicated there was no way of knowing what everyone else was paid. When asked about the conflict of interest statement that was read in the January 2012 Board meeting, one Board member did not recall any discussions of conflict of interest in the past. Another member indicated that he did not know if there were any conflicts of interest between AmeriHealth Mercy and UHC. He noted the Board was strict on rates never being done at the Board level because of conflicts of interest. He noted the exception was charity care and the capital ownership returns. Another indicated they have addressed the subject in the past few meetings, including Board governance. He stated it was not the first time the subject has come up but it was most likely the first time it was read aloud. The third interviewee indicated that by the very nature of the organization, he believes there will always be a potential for conflicts of interest in a provider-based organization; however he did not recall any significant conflict of interest discussions in regards to individual actions. He felt that provider members dealt with this appropriately and the provider network is generally "OK" with the rates.

It appears Board members were aware that Passport would sponsor golf tournaments and buy tables at events, but it was unclear to one interviewee as to whether these disbursements were ever brought before the Board for board approval. Grants were brought to the Board and the Board would approve such grants (including Kangaroo Camp and Pregnant Women Shelter), but the interviewee was unsure if all grants were brought to the Board. When asking another member if there were any grants that were issued that did not come before the Board for approval, the response was that it depended on the definition of "grant". The member went on to say that if a grant is considered something where there is an application, the grant committee will rank the grant applications and make a decision on which grants to bring to the Board for Board approval. If a "grant" is considered something where there is a decision to buy a table at a fundraising event, then it would not necessarily come before the Board. Major financial decisions such as safety net grants and repayment of capital would come before the Board for an approval decision. When asking this member if there was a specific dollar value threshold requiring Board notification and/or approval, the response was there was no limit established. The member gave the example that if senior management decided to buy a table at the Heart Ball, that item did not come before the Board other than being included in the budget/income statement. PHP indicated that this process has been evaluated and the controls made more robust in order to ensure the appropriateness of the decision-making process.

Board members confirmed no compensation was received for their time served on the Board and knew of no instances where someone was receiving compensation. Additionally, members typically were not reimbursed for expenses and only one member recalled traveling out of state for Board business. This trip was at the inception of Passport and the member, along with other Board members, met with AmeriHealth Mercy in Philadelphia to look at their operations. The member was unsure if the accommodations and travel expenses were paid by AmeriHealth Mercy or by Passport.

He also noted there was one night of entertainment at a museum with AmeriHealth Mercy senior staff and Board members and believes AmeriHealth Mercy covered those expenses. This member also noted that the Chairman of the Board did more traveling on Passport business.

When asked regarding concerns about the way the Board operated in the past, one member indicated one party (referencing the University of Louisville) has majority control. Although the by-laws were amended (according to the June 21, 2011 meeting minutes, the UHC Partnership Council By-laws were unanimously approved) to change the Board representation, the University of Louisville still has the same percent of representation, so the majority of the decision-making power still rests with one party. Had the recent merger been successful, Jewish/St. Mary's would have been included in the majority control of University of Louisville. Thus, there was very little objection to the amendment. This member indicated at least now, the voting and discussions are in front of the Partnership Council and others who are on the Board. He believes there are more transparency with management and more control over the organization. He indicated AmeriHealth Mercy's role is now more of a third party. Although no conflicts of interest have occurred yet with the new organization of the Board, the potential still exists due to the University of Louisville control of board positions.

Another concern was in regards to Passport's past relationship with AmeriHealth Mercy. The interviewee indicated the model is very different now than it was in prior years. Previously, Passport had contracted AmeriHealth Mercy employees in management positions, including contractor oversight. This led to concerns of conflict of interests. Now, nearly all management and staff are employees of Passport. UHC contracted with AmeriHealth Mercy because their managed care and operational expertise was needed to operate Passport at inception of the Plan. This member felt that had Passport moved from "contracted" to "employee" sooner, they may have avoided certain problems.

Board members appeared to be content with the way Passport and the Board is operating now. One member indicated "Now that the Board chair and president and CEO are independent from UofL, it is very positive." Additionally, now that Passport is doing compliance, "it (Passport operations) has vastly improved." Additionally, this member noted that as a result of the prior (APA) audit, Passport has taken action to make sure there is proper oversight going forward.

One interviewee indicated that the Board has found executive leadership that has taken the Plan to a place where they are operating at a level at which the State is comfortable.

Partnership Council Survey Results

A Passport Health Plan Partnership Council Survey was developed to capture information regarding the members who served on the Board of the Partnership Council, including the identification of the positions held, attendance records, subcommittees, council member's compensation (monetary and non-monetary),

benefits received by the Council member's organization, and the identification of any relationships between the Council member and Passport Health Plan, AmeriHealth Mercy, or any subcontractors, related parties or venders.

The Passport Health Plan Partnership Council Board Member Survey was sent on January 16 and 17, 2012, to all members with valid email addresses. A total of 29 surveys were sent. Of the 29 surveys, surveys were returned from 18 members.

Below are the responses to *Survey Question #5 Approximately how many Partnership Council meetings have you / did you attend?*

Council Member Attendance					
Council Member	**Organization[7]**	**Year**	**Total # of Board Meetings**	**# Attended In Person**	**# Attended by Phone or Internet**
Deom	Deom Health Enterprises	2008	6	2	0
Hedrick	Physicians to Children & Adolescents	2008	All	all	0
Brill	University Hospital	2008	None		
Howard	Park DuValle Community Health Center	2008	0	0	
Sims	Lincoln Trail District Health Department	2008	7	7	
Franco	UofL Children & Youth Project	2008	All of meetings	Yes	
Monroe	Baptist Hospital East	2008	Approximate (no records)	'6-7	
Wagner	FQHCs	2008	3	3	
Anonymous 1		2008	2	1	
Hougland	Medical School Practice Association	2008	2	0	
Anonymous 2		2008	2	2	
Schoenbaechler	Hall Render Killian Heath & Lyman PSC	2008	7	7	
Zegart	Greater Louisville Medical Society	2008	2	2	0
Moreman, II	Elizabethtown Physicians for Women	2008	2	0	0
Deom	Deom Health Enterprises	2009	6	2	0
Hedrick	Physicians to Children &	2009	All	all	0

[7] The member's organization is the organization the member represented at the time the member served on the Board/Partnership Council and is not necessarily the member's current organization.

Council Member Attendance					
Council Member	**Organization[7]**	**Year**	**Total # of Board Meetings**	**# Attended In Person**	**# Attended by Phone or Internet**
	Adolescents				
Brill	University Hospital	2009	5	5	0
Howard	Park DuValle Community Health Center	2009	0	0	
Sims	Lincoln Trail District Health Department	2009	7	7	
Franco	UofL Children & Youth Project	2009	" (All of meetings)	y	
Monroe	Baptist Hospital East	2009	Approximate-no records	5-6	1
Wagner	FQHCs	2009	7	7	
Anonymous 1		2009	6	2	
Hougland	Medical School Practice Association	2009	6	3	0
Anonymous 2		2009	6	3	
Schoenbaechler	Hall Render Killian Heath & Lyman PSC	2009	7	7	
Zegart	Greater Louisville Medical Society	2009	6	2	0
Moreman, II	Elizabethtown Physicians for Women	2009	6	3	0
Deom	Deom Health Enterprises	2010	6	6	0
Hedrick	Physicians to Children & Adolescents	2010	All	all	0
Brill	University Hospital	2010	3	3	0
Howard	Park DuValle Community Health Center	2010	0	0	
Sims	Lincoln Trail District Health Department	2010	7	7	
Franco	UofL Children & Youth Project	2010	All of meetings	y	
Monroe	Baptist Hospital East	2010	Approximate-no records	6-7	
Miller		2010	6	5	
Wagner	FQHCs	2010	7	7	
Anonymous		2010	7	3	
Hougland	Medical School Practice Association	2010	7	6	0
Anonymous 2		2010	6	3	

Council Member Attendance					
Council Member	**Organization[7]**	**Year**	**Total # of Board Meetings**	**# Attended In Person**	**# Attended by Phone or Internet**
Schoenbaechler	Hall Render Killian Heath & Lyman PSC	2010	7	7	
Zegart	Greater Louisville Medical Society	2010	7	4	0
Moreman, II	Elizabethtown Physicians for Women	2010	7	1	0
Deom	Deom Health Enterprises	2011	7	5	
Hedrick	Physicians to Children & Adolescents	2011	All	all	0
Brill	University Hospital	2011	5	5	0
Howard	Park DuValle Community Health Center	2011	7	7	0
Sims	Lincoln Trail District Health Department	2011	7	7	
Franco	UofL Children & Youth Project	2011	All except 2	y	
Monroe	Baptist Hospital East	2011	Approximate-no records	6-7	
Miller		2011		7	5
Wagner	FQHCs	2011	4	4	
Anonymous		2011	5	4	
Hougland	Medical School Practice Association	2011	5	1	0
Anonymous 2		2011	5	2	
Schoenbaechler	Hall Render Killian Heath & Lyman PSC	2011	7	7	
Zegart	Greater Louisville Medical Society	2011	5	5	0
Moreman, II	Elizabethtown Physicians for Women	2011	8	4	0

Upon analysis of the Council responses, all members responded that a quorum was required for voting decisions (with the exception of one member who didn't provide the first page of the survey) and most quoted 10 members were required for a quorum.

Most members were unsure who nominated them to the Council, and a few indicated Bill Wagner (Council Member) nominated him/her. One member indicated Gerard Rabalais (Council Member) was the nominating person.

All Council members responding to the survey indicated they did not receive any compensation. Two members indicated they received meals served during the meeting, otherwise no other compensation or bonuses were received. In regards to expenses, Council members either indicated no expenses were reimbursed or that travel expenses to/from the meeting were reimbursed by their practice. The only gifts noted by the Partnership Council members were the meals provided at the meetings by Passport/UHC, one member noting a "10-year anniversary paper weight" was received from Passport with an approximate value of $15, one member indicating candy, and another member noting a Passport binder worth less than $30 was provided by Passport.

Additionally, one member indicated they attended some events by UHC invitation, which included the Greater Louisville, Inc – Healthcare Update, the Doctor's Ball and the Fundraiser for Bridgehaven (mental health services).

Of the 18 surveys returned, eight Council members indicated they are enrolled as a Medicaid/Passport provider. Others responding to the survey may not be specifically enrolled as a provider, but their employer may be enrolled. The specialties indicated were for internal medicine, OB-GYN, pediatrics, local health departments, family medicine, geriatrics, optometry, and pharmacy. All members indicated they did not receive any benefits for their practice as a result of their membership on the Council.

When asked if the Council member or their family members have any other businesses that conducted business, sold products, or performed service with Kentucky Medicaid or Passport Health Plan, members predominantly answered no. One member indicated "As a provider in the health department that I supervise, we contract for clinical services for Passport patients." Another responded "Physician with UofL and University Medical Associates, past member of the board of UMA. Past *[sic]* Medical Director of Univ. Physician Associates."

When asked if the member's practice or family's practice received any Passport provider incentives during the time the member served on the Partnership Council, only three responded affirmatively. One member provided a spreadsheet of the incentive amounts and the other two indicated they were unable to quantify the amounts at the time of completing the survey.

Members were also asked if they had a role in determining and/or approving the incentives. Based on the responses received and the interviews conducted, it appears the Council members have a role in developing the incentives, but do not have final approval of the standards set for the incentives nor the individual incentives that are paid out to providers. The final approval of incentive standards comes at the UHC Board level. It was indicated by one Council member that PHP staff determine which PCPs met the performance criteria and determine the incentive payments. Another member indicated he heard the information for the incentives and supported the decision made by the PHP board. He also indicated they mostly just share information via the minutes, notes, and discussion of the PHP Board meeting minutes. Another

Council member indicated he "had a vote to approve or disapprove the program criteria as presented". He also indicated, "the PCP committee developed the criteria and if the PC approved the program, it was sent on to the UHC Board for final decision to approve or not." Another member also indicated they "voted each year with the rest of the Board (Partnership Council) to approve the incentive plan". He indicated, "The Plan each year sets certain guidelines that need to be met for a provider to get the incentive. These incentive bonuses are available to each provider in the network."

Partnership Council Member Interviews

Interviews were conducted by phone with two Partnership Council members on January 23, 2012. Both members interviewed have been in their practice field for over 15 years and served on the Partnership Council during the entire examination period.

One member indicated his practice has been involved with Passport since the inception and at the time of inception, it was explained that Passport would be owned by the hospitals. In the beginning, however, this plan was skewed towards the University of Louisville, so the rural providers protested and as a result of his vocal presence, this member was appointed to the Partnership Council.

During the interviews, it was noted the Partnership Council helps to fine tune Passport's policies. Additionally, the PCP Committee will review the incentive bonus standards presented by AmeriHealth Mercy, who sets these standards to improve HEDIS measures. The PCP Committee discusses ways to structure the incentive plan to increase quality of care. The PCP Committee will tell Passport whether the plan is doable and whether the goals are attainable. The interviewee gave examples of incentives for asthma and emergency room (ER) visits.

One of the incentive goals noted was to try to dissuade members from using the ER when an office visit is more appropriate. The Council member stated that Passport members (patients) will go to the ER because they will not have to pay a copayment, whereas in the office setting, they would be required to do so. The incentive goal was to encourage practitioners to increase their office hours to allow more patients to be able to go to the office instead of the ER. For this, practitioners would receive an incentive bonus. However, once implemented, rural providers noticed they were at a disadvantage because they did not have urgent care clinics in the rural areas like those in urban areas. The urgent care visits were not counted as ER visits. Through the Partnership Council discussion of this situation, the incentive was removed because providers could not compete equally.

Another example provided was incentives for obesity clinics. Passport, according to the interviewee, was paying a significant amount for patients to go to these clinics, located in Jefferson County. The incentive related to these clinics was also repealed by the Council.

One of the interviewees noted “in the beginning, (Passport) owners got greedy and considered Passport a cash cow and lost track of helping save money for the state. They were not giving the money back to providers who are seeing the patients, so the Partnership Council was formed.” The interviewee noted “Passport, however, is the best formulary” and “if we (providers) can show a child needs a medicine, Passport will provide.” Included in the interviewee’s comment was that Passport has “what’s best for the patient” mentality.

√ Observations, Findings or Recommendations Related to Business Relationships

1) UHC provided a limited number of policies and procedures that were in effect during the examination window. In fact, many of the documents provided were newly drafted in 2011. In responding to our requests for policies and procedures in effect during the examination window, UHC responded as follows:

   - A board charter was not identified.
   - A board member appointment policy was not identified.
   - A board member termination policy was not identified
   - Term limits were not identified
   - An expense reimbursement policy was not identified.
   - A gift/gratuities policy was not identified
   - An in-kind payment policy was not identified
   - A perquisite /fringe benefit policy was not identified

   Additionally, we were unable to locate within board meeting minutes a process to formally adopt Passport Health Plan policies and procedures.

2) Although a travel expense policy is now in effect, including a provision which requires that travel expenses of the vice president and CEO will be reviewed quarterly, it did not appear the board has established any expense limits requiring board approval, thresholds that would require review regardless of position, or an alternative approval or oversight process for areas that may not have adequate oversight, controls, or supervision. PHP did indicate that travel requires prior approval.

3) UHC provided a limited number of Partnership Council policies and procedures that appears to be in effect during the examination window. In responding to our requests for policies and procedures in effect during the examination window, UHC did not provide the following:

   - A Partnership Council board charter
   - Educational background requirements
   - Expense reimbursement
   - Gift/gratuities policy
   - In-kind payment policy

4) Educational and experience requirements for application to the Partnership Council were not outlined in the Partnership Council Application and no policy was provided by UHC that outlined the education/experience requirements for the various Partnership Council positions.

OBJECTIVE 1F: SUPPLEMENTAL PAYMENTS

The research objectives of this analysis included the following components:

- Review safety-net payments, medical education payments, and graduate medical education payments
- Describe how payments are computed
- Describe conditions of eligibility for payments, or applicable restrictions on the use of funds
- Review additional supplemental payments such as Intensity Operating Allowance (IOA) payments, Urban Trauma Center payments, Healthy for Life (HfL) payments and payment for the SANE program

General Approach to Analysis

Myers and Stauffer developed a data and documentation request that was sent to Passport Health Plan. This request solicited information regarding any non-claim specific payment, including safety-net payments, medical education payments, or graduate medical education (GME) payments made to Passport enrolled providers during the examination window. Work plan activities included analysis of the supporting/authorizing provisions of the Medicaid State Plan, the contract between DMS and UHC, the Kentucky Administrative Regulations (KAR), and the Code of Federal Regulations (CFR). We also analyzed reports and other source materials that were submitted by PHP.

We attempted to analyze the process used by Passport to compute payments and how payments were distributed to providers by cross-referencing the formulas provided in the Kentucky Administrative Regulations and the Section 1115 Medicaid Waiver. We analyzed applicable policies and procedures, and conducted interviews with certain health plan personnel. In some cases we solicited third-party verification as a means to identify the universe of payments and to confirm that the intended party received and retained the payments.

For purposes of this report, please note that we have used interchangeably the terms "non-claim benefit expenditures", "non-claim benefit payments", "supplemental payments", and "non-claim specific payments." These terms refer to payments made by Passport for eligible services that are not based on a single episode of care. However, these terms do NOT refer to sub-capitation payments.

Guiding Parameters for Non-Claim Benefit Expenditures

As part of the analysis of non-claim benefit expenditure payments, we analyzed the requirements of the Medicaid State Plan, the contract between DMS and UHC, the Kentucky Administrative Regulations, the Code of Federal Regulations, Medicaid provider manuals, and PHP policy and procedure manuals.

These guiding parameters are excerpted and included in the sections below. To enhance readability, we have modified line spacing, inserted indentations, removed superfluous text, and inserted acronyms where appropriate. We did not modify language or section/title/paragraph references, such that excerpts may be easily cross-referenced back to the corresponding original documents.[8]

Contract

We reviewed the contract "Medicaid Health Care Contractor Contract" between DMS and Passport Health Plan for SFY 2009, 2010, 2011, and 2012.

Page	Section	Contract Requirement
32	3.8	**Financial Information: Payment to Teaching Hospitals** ***In establishing payments for teaching hospitals in its Contractor's Network, the Contractor shall recognize costs for graduate medical education, including adjustments required by KRS 205.565 and 907 KAR 10:825.***

Kentucky Administrative Regulations (KAR)[9]

We analyzed Title 907 of the KAR to identify potential regulations related to GME, medical education (ME) and safety-net payments. Our analysis also included Rule 705 of Chapter 1, which is the basis of the Partnership Program Demonstration, under Section 1115 of the Medicaid waiver. Below are excerpts from chapters and sections within Title 907 including, as applicable safety-net payments and GME payments.

[8] Acronyms and reference word inserts can be identified by brackets "[ ]". Areas where superfluous text has been removed can be identified by three periods "…". In some cases we inserted spaces between lines to improve readability. Emphasis on specific sections can be identified by underlined bolded text in italics...

[9] The citations of the Kentucky Administrative Regulation are based on the following formula: *Title ▪ KAR ▪ Chapter: Rule ▪ Section*

907 KAR 10:825 – Section 5	
Requirements	Direct Graduate Medical Education Costs at In-state Hospitals with Medicare-approved Graduate Medical Education Programs. 1) If [FFP] for direct graduate medical education costs is not provided to the department, pursuant to federal regulation or law, the department shall not reimburse for direct graduate medical education costs. 2) If [FFP] for direct [GME] costs is provided to the department, the department shall reimburse for the direct costs of a [GME] program approved by Medicare as follows: a) A payment shall be made: 1. Separately from the per discharge and per diem payment methodologies; and 2. On an annual basis; and b) The department shall determine an annual payment amount for a hospital as follows: 1. The hospital-specific and national average Medicare per intern and resident amount effective for Medicare payments on October 1 immediately preceding the universal rate year shall be provided by each approved hospital's Medicare fiscal intermediary; 2. The higher of the average of the Medicare hospital-specific per intern and resident amount or the Medicare national average amount shall be selected; 3. The selected per intern and resident amount shall be multiplied by the hospital's number of interns and residents used in the calculation of the indirect medical education operating adjustment factor. The resulting amount shall be the estimated total approved direct [GME] costs; 4. The estimated total approved direct [GME] costs shall be divided by the number of total inpatient days as reported in the hospital's most recently finalized cost report on Worksheet D, Part 1, to determine an average approved [GME] cost per day amount; 5. The average [GME] cost per day amount shall be multiplied by the number of total covered days for the hospital reported in the base year claims data to determine the total [GME] costs related to the Medicaid Program; and 6. Medicaid Program [GME] costs shall then be multiplied by the budget neutrality factor.

Kentucky Revised Statutes (KRS)

As required by the contract, KRS 205.565 requires the Cabinet to recognize the unique costs of a pediatric teaching hospital. Payments under this requirement are unrelated to medical education, GME, or safety-net payments.

KRS 205.565	
Requirements	**205.565 Cabinet to recognize unique costs of pediatric teaching hospital.** (1) For the purposes of this section, a "pediatric teaching hospital" is defined as an acute-care hospital as licensed under KRS Chapter 216B and which has designated and operates no less than one hundred fifty (150) beds for pediatric services and which is either operated by one (1) of the Commonwealth's schools of medicine and which has a pediatric teaching program or which has an affiliation agreement for pediatric services, teaching, and research with a school of medicine for the Commonwealth. (2) For purposes of inpatient hospital reimbursement under the Kentucky Medical Assistance Program, the Cabinet for Health and Family Services shall recognize the unique costs of any pediatric teaching hospital.

Medicaid State Plan Sections

The applicable sections from Attachment 4.19-A of the Medicaid State Plan which refer to supplemental payments identified in this report are excerpted below.

Page	Approved	Effective	Paragraph 31
20	06/25/2009	01/05/2009	Intensity Operating Allowance Inpatient Supplement Payments

Requirements

a. Beginning October 15, 2007, a State owned or operated University Teaching Hospital, including a hospital operated by a related party organization as defined at 42 CFR 413.17, which is operated as part of an approved School of Medicine, shall be based on the upper payment limits as required by 42 CFR 447.272 and will be determined prospectively each year based on the difference between the total payments made by Medicaid, excluding DSH, and the estimated Medicare payments for the same services.

b. The detailed formula to determine the supplemental payments is described in Exhibit B incorporated as part of [4.19-A].

c. The prospective supplemental payments will be reconciled annually to the final cost report filed for the rate year or prospective payment period.

d. Any payments made under subsection a of this section are subject to the payment limitations as specified in 42 CFR447.271, whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

e. Payments made under this section shall be prospectively determined quarterly amounts, subject to a year-end reconciliation...

f. In the event that any payment made under this section is subsequently determined to be ineligible for [FFP] by [CMS], the [DMS] shall adjust the payments made to any hospitals as necessary to qualify for FFP.

g. Pediatric Teaching Hospital

A state designated pediatric teaching hospital that is not state-owned or operated shall receive a quarterly pediatric teaching supplement in an amount:

1) Calculated by determining the difference between Medicaid costs …and payments received for the Medicaid recipients … and including,

2) An additional quarterly payment of $250,000… (Medicaid recipients shall not include recipients receiving services reimbursed through a Medicaid managed care contract.)

Page	Approved	Effective	Title
21	06/25/2009	01/05/2009	**Supplemental Payments for DRG Psychiatric Access Hospitals**

Requirements

a) For services provided on and after April 2, 2001 the [DMS] shall provide supplemental payments to certain hospitals to assure access to psychiatric services for patients in rural areas…. To qualify for psychiatric access payments a hospital must meet the following criteria:

1. The hospital is not located in a Metropolitan Statistical Area (MSA);
2. The hospital provides at least 65,000 days of inpatient care as reflected in the [DMS]'s Hospital Rate data for Fiscal Year 1998-99;
3. The hospital provides at least 20% of inpatient care to Medicaid eligible recipients …. for State Fiscal Year 1998-99; and
4. The hospital provides at least 5,000 days of inpatient psychiatric care to Medicaid recipients in a fiscal year.

b) Each qualifying hospital will receive a psychiatric access payment amount based on its proportion of the hospital's Medicaid psychiatric days to the total Medicaid psychiatric days for all qualifying hospitals applied to the total funds for these payments. Payments will be made on a quarterly basis in according with the following: Medicaid patient days/ Total Medicaid patient days x Fund = Payment

c) Total Medicaid payments to a hospital from all sources shall not exceed Medicaid charges plus disproportionate share payments. A hospital's disproportionate share payment shall not exceed the sum of the payment shortfall for Medicaid services and the costs of the uninsured. The fund shall be an amount not to exceed $6 million annually.

Page	Approved	Effective	Title
22	06/25/2009	03/31/2009	**Supplemental Payment for Hospitals Paid Using the DRG-Based Methodology**

Requirements

1) Hospitals paid using the DRG payment system shall receive, …supplemental payments for the calendar quarters beginning with the calendar quarter ending March 31, 2009 and ending with the calendar quarter ending on December 31, 2010.

2) The aggregate supplemental payments described herein shall not exceed $195,000,000 less any amount set aside that would have gone to those hospitals that decline the supplemental payment and retain their appeal rights.

3) Each hospital's share of the aggregate pool shall be equal to its proportionate share of the projected historical aggregate cost gap of the DRG hospitals, defined as the difference between costs and Medicaid payments for DRG services for the period July 1, 2004 through June 30,2007, trended to the midpoint of the January 2009 through December 2010 payment period.

4) Hospitals receiving the Intensity Operating Allowance Supplement as established in this attachment shall not be eligible for the supplement payments described in this section since they are already receiving a supplement payment.

5) Any payments under this supplemental provision are subject to the upper payment limits…

Page	Approved	Effective	Paragraph 33
21	06/25/2009	01/05/2009	**Appalachian Regional Hospital System supplemental payments**.
Requirements	All DRG hospitals operating in the Commonwealth…that belong to the Appalachian Regional Hospital System will receive an adjusted payment equal to the difference between what Medicaid pays for inpatient services and what Medicare would pay for those same services to Medicaid eligible individuals or its proportionate share of $7.5 Million, whichever is lower. The Upper Payment Limit as defined in 42 CFR 447.272 will be applied on a facility-specific basis as described in Exhibit A [of the Medicaid State Plan]. These payments will be made on a quarterly basis within 30 days of the end of the quarter.		

Page	Approved	Effective	Paragraph 34
21	06/25/2009	01/05/2009	**Supplemental DRG Payments**
Requirements	a. In-state high intensity level II neonatal center. 2) The [DMS] will make prospective supplemental payments to in-state hospitals for all DRGs 675 through 680…to a hospital with a Level II neonatal intensive care unit that meets the following qualifications: a. Is licensed for a minimum of 24 neonatal level II beds; b. Has a minimum of 1,500 Medicaid neonatal level II patient days per year; c. Has a gestational age lower limit of twenty-seven (27) weeks; and d. Has a full-time perinatologist on staff. e. The payment will be an additional add-on per discharge for each of the above DRGs. 3) Before July 1, 2007, the add-on will be $3,775; 4) From July 1, 2007 through-October 14, 2007, the add-on will be $9,853; and 5) On or after October 15, 2007, the add-on will be $2,870. b. The [DMS] will pay no more in the aggregate for inpatient hospital services than the inpatient [UPL]... The [DMS] will determine the inpatient [UPL] by estimating what would be paid for inpatient hospital services under the Medicare principles of reimbursement. The methodology used by the [DMS] to calculate the inpatient [UPL] can be found in [the Medicaid State Plan] Attachment 4.19-A Exhibit A. c. An overpayment made to a facility under this section shall be recovered by subtracting the overpayment amount from a succeeding year's payment to be made to the facility in accordance with applicable federal regulations. ***d. For the purpose of this attachment, Medicaid patient days shall not include days for a Medicaid recipient eligible to participate in the state's Section 1115 waiver as described as the Demonstration project: Services provided through regional managed care partnerships 1115 Wavier.*** e. A payment made under the Supplemental DRG payments shall not duplicate a payment made via Item (8) Disproportionate share hospital distributions.		

Page	Approved	Effective	Paragraph 7
27	06/25/2009	01/05/2009	**Supplemental Payments for a Free-standing In-state Rehabilitation Hospital**
Requirements	A state designated rehabilitation teaching hospital that is not state-owned or operated shall receive all annual rehabilitation teaching supplement payment, determined on a per diem basis, in an amount calculated by determining the difference between Medicaid costs as stated on the cost settled audited cost report each year, and payments received for the Medicaid patients (i.e., Medicare, KMAP, TPL, and Medical Education).		

Code of Federal Regulations

We analyzed 42 CFR 438 (Medicaid Managed Care) to determine the applicability to safety-net payments, medical education, and GME payments.

Code of Federal Regulations	
Citation	**Requirement**
§ 438.6(c)(v) Contract requirements	If a State makes payments to providers for graduate medical education (GME) costs under an approved State plan, the State must adjust the actuarially sound capitation rates to account for the GME payments to be made on behalf of enrollees covered under the contract, not to exceed the aggregate amount that would have been paid under the approved State plan for FFS. States must first establish actuarially sound capitation rates prior to making adjustments for GME.

Contract with DMS and UHC

We reviewed the contract "Medicaid Health Care Contractor Contract" between DMS and Passport Health Plan for SFYs 2009, 2010, 2011, and 2012. The following are excerpts pertaining to maintaining financial transaction records, which would include non-claim benefit expenditures.

Page	Section	Contract Requirement
119	10.1(f)	**Record System Requirements** The Contractor shall maintain or cause to be maintained detailed records relating to the operation of the Contractor's Partnership Program, including but not limited to the following: …(f) All financial records, including all financial reports required under Section 10.6 of this Contract **and A/R activity, rebate data, DSH requests and etc;** **(Bold language added in 2011 contract)**

Page	Section	Contract Requirement
145	Attachment II	**MANAGEMENT INFORMATION SYSTEMS (MIS)** **5.) Financial** **b.) Processing Requirements** **3.) Other Financial Processing** Financial transactions such as stop payments, voids, reissues, manual checks, cash receipts, repayments, cost settlements, overpayment adjustments, recoupment's, and financial transactions processed outside the MIS are to be processed as part of the Financial Processing function.

Kentucky Administrative Regulations[10]

We analyzed Title 907 of the KAR to identify potential regulations related to supplemental payments. Many of these special payment programs are described within Chapter 10 of Title 907. The analysis also included Rule 705 of Chapter 1, which is the basis of the Partnership Program Demonstration, under Section 1115 of the Medicaid waiver. Excerpts from Title 907 are included in the table below.

[10] The citations of the Kentucky Administrative Regulation are based on the following formula:
Title ▪ KAR ▪ Chapter: Rule ▪ Section

907 KAR 10:825 – Section 15 – Supplemental Payments	
Requirements	1) Payment of a supplemental payment … [is] contingent upon…[FFP]. 2) If [FFP] is not provided …, the [DMS] shall not make the supplemental payment. 3) In accordance with subsections (1) and (2) of this section, the [DMS] shall: a) ….. make quarterly supplemental payments to: 1. A hospital that qualifies as a nonstate pediatric teaching hospital in an amount: a) Equal to the sum of the hospital's Medicaid shortfall for Medicaid recipients under the age of eighteen (18) plus an additional $250,000 ($1,000,000 annually); and b) Prospectively determined by the [DMS] with an end of the year settlement based on actual patient days of Medicaid recipients under the age of eighteen (18); 2. A hospital that qualifies as a pediatric teaching hospital and additionally meets the criteria of a Type III hospital in an amount: a) Equal to the difference between payments made in accordance with Sections 2, 4, and 5 of this administrative regulation and the [UPL]; b) That is prospectively determined with no end of the year settlement; and c) ***Based on the state matching contribution made available for this purpose by a facility that qualifies under this paragraph***; and 3. A hospital that qualifies as an urban trauma center hospital in an amount: **a)** ***Based on the state matching contribution made available for this purpose by a government entity on behalf of a facility that qualifies under this paragraph***; b) Based upon a hospital's proportion of Medicaid patient days to total Medicaid patient days for all hospitals that qualify under this paragraph; c) That is prospectively determined with an end of the year settlement; and d) That is consistent with the requirements of [the UPL]; e) Make quarterly supplemental payments to the Appalachian Regional Hospital system: 1. In an amount that is equal to the lesser of: a) The difference between what the [DMS] pays for inpatient services … and what Medicare would …; or b) $7.5 million per year in aggregate; 2. For a service provided on or after July 1, 2005; and 3. Subject to the availability of coal severance funds, in addition to being subject to the availability of [FFP], which supply the state's share to be matched with federal funds; c) Base a quarterly payment to a hospital in the Appalachian Regional Hospital System on its Medicaid claim volume in comparison to the Medicaid claim volume of each hospital within the Appalachian Regional Hospital System; and d) Make a supplemental payment to an in-state high intensity level II neonatal center of $2,870 per paid discharge for a DRG 675 - 680. 4) An overpayment made to a facility under this section shall be recovered by subtracting the overpayment amount from a succeeding year's payment to be made to the facility. **5)** ….. ***Medicaid patient days shall not include days for a Medicaid recipient eligible to participate in the state's Section 1115 waiver as described in 907 KAR 1:705.*** 6) A payment made under this section shall not duplicate a payment made via 907 KAR 1:820. 7) A payment made in accordance with this section shall be in compliance with the limitations established in 42 C.F.R. 447.272.

907 KAR 10:183 – Section 2	
Requirements	Supplemental Payments to DRG Hospitals Which Have Agreed To Accept the Payments. 1) The department shall issue eight (8) payments: a) To a hospital: 1. Reimbursed via the DRG reimbursement methodology which agreed, in April 2009, to accept the supplemental payments; and 2. As a supplement to its reimbursement for inpatient hospital services paid via the DRG reimbursement methodology; b) Beginning with two (2) payments issued during the calendar quarter ending June 30, 2009, followed by one (1) payment for each subsequent calendar quarter until the quarter ending December 31, 2010; and c) Representing calendar quarters beginning with the calendar quarter ending March 31, 2009 and ending with the calendar quarter ending on December 31, 2010. 2) A supplemental payment referenced in subsection (1) of this section shall be paid from an aggregate supplemental payment pool: a) That shall not exceed $195 million; and b) That shall be reduced by the amount of the share of a hospital, if any, that foregoes its share of the aggregate supplemental payment pool in accordance with Section 3 of this administrative regulation. 3)A hospital's share of the aggregate supplemental payment pool referenced in subsection (2) of this section shall: a)Equal its proportionate share of its aggregate cost gap compared to the aggregate cost gap of all hospitals reimbursed via the DRG reimbursement methodology: 1. Which agreed to accept the supplemental payments referenced in subsection (1) of this section; and 2. Except for the excluded hospitals referenced in Section 4(2), (3), or (4) of this administrative regulation; b) Be divided into thirty-six (36) equal units; and c) Be paid on a descending balance basis with the: 1. First quarterly payment representing eight (8) equal units; 2. Second quarterly payment representing seven (7) equal units; 3. Third quarterly payment representing six (6) equal units; 4. Fourth quarterly payment representing five (5) equal units; 5. Fifth quarterly payment representing four (4) equal units; 6. Sixth quarterly payment representing three (3) equal units; 7. Seventh quarterly payment representing two (2) equal units; and 8. Eighth quarterly payment representing one (1) unit.

907 KAR 10:815 – Section 17 – Supplemental Payments	
Requirements	In addition to a payment based on a rate developed under Section 2, 3, or 4 of this administrative regulation, the department shall: 1) Make quarterly supplemental payments to an in-state hospital which qualifies as a psychiatric access hospital in an amount: a) Equal to the hospital's uncompensated costs of providing care to Medicaid recipients and individuals not covered by a third party payor, not to exceed $6 million annually; and b) Consistent with the requirements of 42 C.F.R. 447.271; and 2) Make an annual payment to an in-state state-designated free-standing rehabilitation teaching hospital that is not state-owned or operated in an amount: a) Determined on a per diem or per discharge basis equal to the nonreimbursed costs of providing care to Medicaid recipients. Costs shall be the amount of cost identified on a hospital's most recent cost report received by the department for a fiscal year reduced by the cost of care covered by third parties and b) Equal to the amount of per diem payments pursuant to this administrative regulation or per discharge diagnosis related group payments pursuant to 907 KAR 10:825 received by the hospital for Medicaid recipients not covered by third parties.

Policies and Procedures

We analyzed the Passport Health Plan Provider Manual (updated September 2011) and documents listed on the DMS webpage. The PHP Provider Manual did not appear to include any language regarding non-claim benefit payments.

Requests for Data and Documentation

On September 2, 2011, we requested from Passport Health Plan a detail listing of all non-claim-specific payments made during the audit window (i.e., July 1, 2008 through June 30, 2011). Specifically, the request included the following components:

- Detail general ledger for distributions from January 2008 through then current.
- Detail listing of all non-claim-specific payments.
- Detail supporting calculations including formulas, contractual provisions, guidelines, state plan amendments or other regulation/statute authorizing the payment.

In addition to the above requests, we asked PHP to respond to the following questions:

- Does the contract with the Medicaid agency include limitations, restrictions, or requirements for health plan issued/awarded payments? Does the health plan make payments? Please specify contract section and requirements for making payments.

- If the health plan has made payments, how were they computed? What types of entities are eligible for and/or received payments? Please specify whether these entities are health care providers, subcontractors, vendors, or other entity, and whether there is any type of ownership or related party relationship to the health plan.

- How are payments made (i.e., separate payments, invoiced, claim add-on, other)? Who within the health plan oversees and/or monitors payments? What is the Medicaid agency's role (if any) to authorize payments? What are the responsibilities or obligations of the receiving entity?

Health Plan Expenditures for GME, ME, and Safety-Net Programs

As illustrated in the table below, Graduate Medical Education (GME) payments made by Passport account for approximately 51 percent, followed by safety-net payments at 37 percent, and medical education (ME) at 12 percent.

Year	GME	ME	Safety-Net	Grand Total	Percent
2008	$29,492,553	$6,882,846	$22,788,063	$59,163,462	26.5%
2009	$32,629,628	$7,612,075	$26,481,836	$66,723,539	29.6%
2010	$34,234,594	$8,183,086	$23,522,675	$65,940,355	29.3%
2011^	$17,451,511	$4,154,711	$11,355,644	$32,961,866	14.6%
Grand Total	**$113,808,286**	**$26,832,718**	**$84,148,218**	**$224,789,222**	**100.0%**
Percent	**51.0%**	**12.0%**	**37.0%**	**100.0%**	

^2011 data through June 30

Calendar year (CY) 2009 accounted for the largest percentage of payments at nearly 30 percent, based on an approximate 12 percent increase over 2008. Since 2009, expenditures have held at approximately 29 percent (i.e., by annualizing 2011).

Graduate Medical Education (GME)

Medicaid regulations permit payments to hospitals that have residents in an approved graduate medical education (GME) program. 42 CFR 438.6 requires that states adjust actuarially sound capitation rate ranges to include costs for GME reimbursement.

We received and reviewed data explaining the calculation of GME for qualifying hospitals. The calculation has several steps as described below. The calculation example is based on June 2009 data. Please note that the bold "Steps" below represent verbatim responses received from PHP. Therefore, the term "we" used in the calculation means Passport Health Plan.

PHP Step #1: Calculate initial pool of dollars using original 1997 pmpm rates.

Calculate the initial pool of dollars using the original 1997 per member per month rates for each category of aid: Temporary Assistance for Needy Families (TANF); *Sixth Omnibus Budget Reconciliation Act (*SOBRA); Foster Care; Social Security Income (SSI) w/Medicare; SSI without Medicare; Kentucky Children's Health Insurance Program (KCHIP) 2; and KCHIP 3.

Category of aid	Members	Original PMPM Rates	Amount
TANF	41,643	$5.62	$234,034
SOBRA	59,333	$6.97	$413,551
Foster Care	6,264	$5.14	$32,197
SSI with Medicare	12,555	$2.10	$26,366
SSI without Medicare	25,335	$17.43	$441,589
KCHIP 2	9,237	$6.97	$64,382
KCHIP 3	4,638	$6.97	$32,327
			$1,244,445

PHP Step #2: Calculate increase in average capitation revenue per member per month (pmpm) since 1998.

1998 average cap revenue pmpm	$219.93
2009 YTD average cap revenue pmpm	$370.11
Increase	168.29%

PHP Step #3: In order to index the GME payment to the increase in revenue rates, we need to multiply the initial pool (Step #1) by the average capitation revenue increase (Step #2).

Initial pool	$1,244,445

PMPM increase	168.29%
Indexed amount	$2,094,219

PHP Step #4: The decision was made to pay all GME recipients the same rate per resident, using Norton's rate. Therefore [PHP]we need to calculate Norton's rate per resident.

Indexed amount (Step #3)	$2,094,219
% of initial pool historically allocated to Norton	39.79%
Norton's allocation	$833,290
Norton's # of residents	133.83
Norton's rate per resident	$6,226

Myers and Stauffer was informed that an adjustment[11] was made to the per member per month cost rates based on the Norton cost rate (i.e., hospital's with GME rates less than the Norton rate received an adjustment up to the Norton rate):

- Begin with indexed amount from #3 above.
- Multiply by percentage of initial pool historically allocated to Norton (39.79 percent for these time periods).
- Divide by Norton number of residents will equal the Norton current month rate per resident.
- Multiply Norton rate per resident by number of residents to arrive at the GME payment.

Based on the calculations above, the GME rate per resident for June 2009 was $6,226. The table below illustrates that rate was used for June GME payments. There were 440.7 residents among all hospitals. Therefore, total GME payments for June 2009 were $2.7 million. For calendar year 2009, total GME payments were $32.6 million, paid

[11] PHP staff indicated that a change was made to improve equity among qualifying hospitals.

to three hospitals in the PHP region: Jewish Hospital / St. Mary's Healthcare Services (Jewish/St. Mary's), Norton Healthcare, and University Medical Center (UMC).

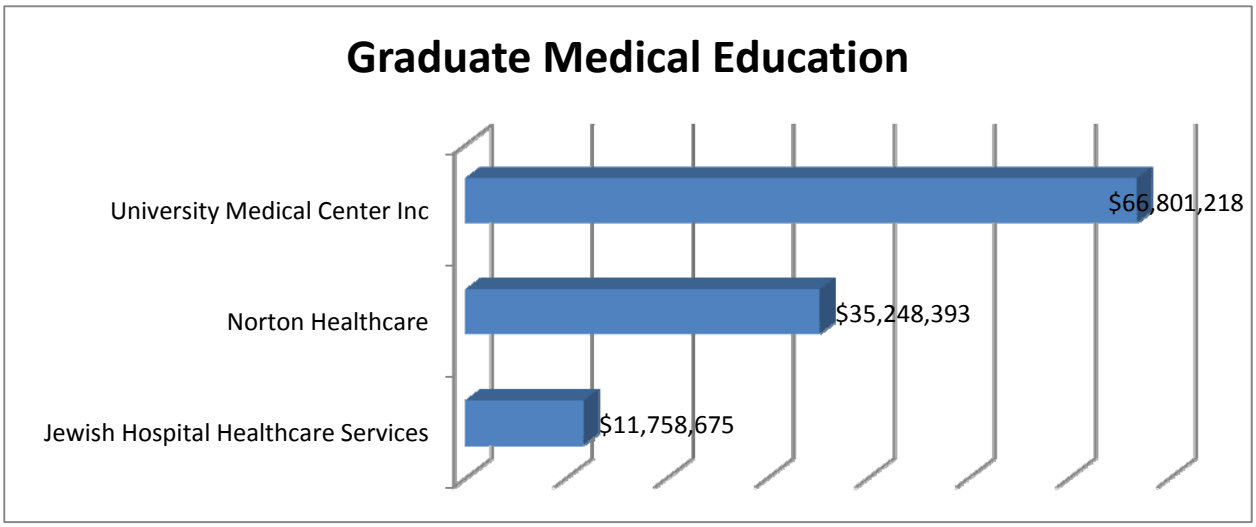
CALENDAR YEAR 2009 GME PAYMENTS			
Month	**Resident Count**	**Rate Per Resident**	**Monthly GME Payments**
Jan	440.7	$5,916	$2,606,999
Feb	440.7	$5,975	$2,632,980
Mar	440.7	$5,996	$2,642,405
Apr	440.7	$6,127	$2,699,859
May	440.7	$6,036	$2,659,802
Jun	**440.7**	**$6,226**	**$2,743,725**
Jul	440.7	$6,128	$2,700,272
Aug	440.7	$6,349	$2,797,725
Sep	440.7	$6,305	$2,778,324
Oct	443.7	$6,191	$2,746,622
Nov	443.7	$6,310	$2,799,352
Dec	443.7	$6,360	$2,821,562
TOTAL			$32,629,627

Passport provided the 2009 GME calculations from the databook used to set capitation rates. The following table includes the databook calculations. For CY 2009, PHP made GME payments of $32,629,627 and had revenue of $32,615,758. DMS confirmed that GME payments are appropriately addressed in the databook used to establish capitation rate ranges.

Category of Aid	January - June 2009 Actual Members	GME PMPM Rate Per DMS Databook	Calculated GME Funding	July - December 2009 Actual Members	GME PMPM Rate Per DMS Databook	Calculated GME Funding	Total Calendar 2009
TANF Adult	85,776	$12.51	$1,073,058	86,612	$12.31	$1,066,194	$2,139,251
TANF Children	160,186	$12.51	$2,003,927	161,677	$12.31	$1,990,244	$3,994,171
Foster Care	37,283	$11.44	$426,518	37,797	$11.26	$425,594	$852,112
KCHIP 2	55,472	$15.52	$860,925	58,183	$15.26	$887,873	$1,748,798
KCHIP 3	26,872	$15.52	$417,053	29,097	$15.26	$444,020	$861,074
Presumptive Eligible	2,693	$-	$-	2,492	$-	$-	$-
SOBRA Adult	36,353	$15.52	$564,199	39,463	$15.26	$602,205	$1,166,404
SOBRA Children	296,577	$15.52	$4,602,875	332,233	$15.26	$5,069,876	$9,672,751
SSI with Medicare	74,992	$4.68	$350,963	75,829	$4.60	$348,813	$699,776
SSI without Medicare	149,132	$38.17	$5,692,368	151,665	$38.17	$5,789,053	$11,481,421
Total			**$15,991,886**			**$16,623,872**	**$32,615,758**

Graduate Medical Education Expenditures

Over the course of the audit window, total GME payments made by PHP were $113.8 million, distributed to three hospitals. University Medical Center accounted for approximately 59 percent of the payments, Norton Healthcare accounted for 31 percent, while Jewish/St. Mary's accounted for 10 percent.



Hospitals	2008	2009	2010	2011	Grand Total
Jewish Hospital Healthcare Services	$3,319,305	$3,322,068	$3,357,129	$1,760,173	$11,758,675
Norton Healthcare	$9,041,549	$9,999,487	$10,749,584	$5,457,773	$35,248,393
University Medical Center Incorporated	$17,131,699	$19,308,073	$20,127,881	$10,233,565	$66,801,218
Grand Total	**$29,492,553**	**$32,629,628**	**$34,234,594**	**$17,451,511**	**$113,808,286**

In response to the survey questions B3.32 through B3.35, PHP provided additional detail regarding graduate medical education expenditures.

- (B3.32) Does the contract with the Medicaid agency include limitations, restrictions, or requirements for health plan issued/awarded payments for GME? Does the health plan make payments for GME? Please specify contract section and requirements for making GME payments.
  ***PHP Response**: Yes to both questions, 3.7 Payment of Teaching Hospitals. In establishing payments for teaching hospitals in its Contractor's Network, the Contractor shall recognize costs for graduate medical education, including adjustments required by KRS 205.565 and 907 KAR 10:825.*

- (B3.33) If the health plan has made GME payments, how were they computed? What types of entities are eligible for and/or received payments for GME? Please specify whether these entities are health care providers, subcontractors, vendors, or other entity, and whether there is any type of ownership or related party relationship to the health plan.
  PHP Response: "*Graduate Medical Education is defined as any type of formal, usually hospital-sponsored or hospital-based training and education, that follows graduation from a medical school, including internship, residency, or fellowship*.

Payments to each hospital are based on the following:

- *Current Medicaid membership.*
- *Number of residents at each hospital.*
- *Cost per resident.*

The types of entities that are eligible for GME payments are hospitals that provide training and education for individuals that have graduated from medical school, including internship, residency, or fellowship.

All entities that received GME payments from University Health Care are hospital providers and are considered related parties to Passport."

- (B3.35) How are GME payments made (i.e., separate payments, invoiced, claim add-on, other)? Who within the health plan oversees and/or monitors GME payments? What is the Medicaid agency's role (if any) to authorize GME payments? What are the responsibilities or obligations of the receiving entity?
  PHP Response: "*All GME payments are made to hospital providers as a separate payment in the form of a check to the provider. David Stanley, Chief Financial Officer, approves these calculations for payment*."

Medical Education (ME)

Medical education payments were identified as being paid to the University of Louisville Research Foundation and otherwise classified as GME payments in the payment detail documentation we obtained. Medical education payments of $26.8 million were paid from January 2008 through June 2011. UofL Research Foundation is the only entity that received medical education payments. DMS informed us that medical education payments were appropriately considered in the calculation of the capitation rate ranges. Please note that DMS informed us that the medical education payment program was restructured effective July 1, 2011, including a new name and Upper Payment Limit based calculation methodology.

- 2008 $6,882,846
- 2009 $7,612,075
- 2010 $8,183,086
- 2011 $4,154,711

Passport provided the following explanation regarding the calculation of medical education payments:

The amount going to the UofL Medical School is calculated as 30.29 percent (allocation percentage developed at initiation of the health plan) of the adjusted total from step #1 of the Graduate Medical Education Payment Calculations.

The remaining amount is allocated to the three teaching facilities based on allocation percentages developed at initiation of the health plan.

The table below summarizes the ME revenue and expense information submitted by the medical school. The balance of the account as of June 30, 2011 was $10.9 million.

State Fiscal Year								
(In Millions)	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**Total**
ME Revenue	$3.74	$4.90	$6.18	$5.76	$6.57	$7.18	$7.96	$42.31
Expenditures	$6.10	$3.40	$4.74	$4.21	$3.20	$8.25	$6.47	$36.38
Surplus / (Deficit)	($2.36)	$1.50	$1.45	$1.55	$3.37	($1.07)	$1.49	

Question and Answer with Medical School Personnel (responses reflect content without modification.)

What were the roles and responsibilities including sign-offs, approvals and oversight of The Passport Board of Directors, The Cabinet, and UofL including its Board of Trustees and Executive Leadership Officers, and UPG / MSPA / UPG?

The allocation formula was developed by the MSPA/UPG board and approved by the VP Health Affairs and Dean, School of Medicine. The Passport board was aware of the distribution formula. DMS was not involved in the process nor was the UofL Board of Trustees. The VP Health Affairs and Dean, School of Medicine, who would be considered "executive leadership" was fully aware of the process and calculation.

What was the justification and process for allocating medical education funds within the University of Louisville? Who approved the process? What restrictions if any were placed on the use of these funds? Who received these funds and how were they utilized?

The initial distribution to clinical departments was based on a formula developed by the MSPA/UPG board. The process was approved by the VP Health Affairs and Dean, School of Medicine. No particular restrictions were placed on the use of the funds other than general support of the medical education program. The clinical departments received a portion (approx $2M per year) of the funds which became a part of their regular academic operating budget. The remainder was retained by the VP Health Affairs/Dean and used for support of the VP's office as well as support of various schools of medicine departments.

Were any of these funds allocated outside of the UPG / MSPA / UPA? If so, where were they allocated and upon whose approval?
No

What oversight and compliance actions were put in place to assure the appropriate use of these funds?

No specific oversight or compliance actions relative to the medical education funds were put in place. The funds were expended through normal UofL processes and oversight.

Were unallocated or unspent medical education funds allowed to accumulate if so what has been the historical balances of these accounts?

Yes. Balances in the account at June 30 were $11,896,082, $12,793,420, and $10,951,297 for FY2009, FY2010, and FY2011 respectively.

Provide the name of the account holder for the account which is used to retain the [medical education] funds that are controlled by the EVPHA? For instance, is that UofL, UPA, the UofL Foundation or some other entity?

..It is the University of Louisville Research Foundation, Inc. This is an "affiliated corporation" under KRS Chapter 164A, which means it is set up to act as an agent of the University in carrying out part of its mission (in this case Health Sciences Activities). I will confirm that with Maurice Snook in the morning. If not in a ULRF account, it would have been in a University account. UPA and the University of Louisville Foundation are separate corporations, and would never be holding University money. UPA was given the safety net money because it was responsible for the teaching clinics which the safety net money supported. UPA would not have gotten the medical education money. The UofL Foundation administers charitable contributions by individuals on behalf [of] the University, and is not involved in the operations of the Health Sciences Center.

Safety-Net Payments

Between 2008 and 2011, Safety-Net expenditures were approximately $84.1 million. Three facilities received safety-net payments over the course of the audit window: UofL Primary Care received payments of approximately $53.8 million; Family Health Centers received $24.4 M; and Park DuValle Health Center received $6.0 M. The table below illustrates the safety-net payment amounts paid by PHP State fiscal year and by the receiving entity. Please note that DMS informed us that the safety-net payment program was restructured effective July 1, 2011, including a new name and calculation methodology.

	State Fiscal Year					
Facilities	**2008**	**2009**	**2010**	**2011**	**Grand Total**	**Percent**
Family Health Centers	$6,583,471	$7,650,601	$6,835,514	$3,280,645	$24,350,231	28.9%
Park DuValle Health Center	$1,661,255	$1,930,529	$1,587,040	$827,828	$6,006,652	7.2%
UofL Primary Care	$14,543,337	$16,900,706	$15,100,121	$7,247,171	$53,791,335	64.3%
Grand Total	**$22,788,063**	**$26,481,836**	**$23,522,675**	**$11,355,644**	**$84,148,218**	**100.0%**
Percent	**27.0%**	**31.5%**	**28.0%**	**13.5%**	**100.0%**	

During the period of the examination, organizations qualifying for financial support from the safety-net fund were required to meet the following criteria:

1. Licensed primary care center.
2. Federally defined sliding-fee-scale.
3. Report monthly level of Indigent care provided.
4. At least 25 percent of the patient population is uninsured and below federal poverty level.

Primary Care Centers

The Commonwealth of Kentucky is unique in its reimbursement of primary care centers (PCC). For purposes of covered services and payment rates, PCCs are defined similarly to FQHCs and RHCs.

Kentucky Administrative Regulations address services and payments of PCCs at 907 KAR 1:054 and 907 KAR 1:055. Both regulations authorize the Cabinet for Health and Family Services, Department for Medicaid Services (DMS)(KRS 205.520(3), to comply with any requirement that may be imposed by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation established the provisions relating to primary care centers, FQHCs and RHCs. Myers and Stauffer summarized these regulations below:

907 KAR 1:054. Primary care center and federally qualified health center services

This regulation specifically defines in Section 2 what types of primary care services are covered. It states in subsection (1) "The department shall cover, and a primary care center shall provide, the following services…," and goes on to list services most commonly associated with a primary care provider. Section 3 addresses FQHC covered services and defers to 42 U.S.C.1395x(aa)(3)and 42 U.S.C. 1396d(l)(2)(A) for specific guidelines.

907 KAR 1:055. Primary care center, federally qualified health center services and rural health clinic services

This regulation establishes the reimbursement for primary care centers, FQHCs and RHCs. Section 3 states "For services provided on and after July 2001, the department shall reimburse a Primary Care Center, FQHC, or RHC an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS) as required by 42 U.S.C. 1396a(aa)."

Calculating Safety-Net Payments

In an attempt to test safety-net payment calculations, we reviewed the contract between DMS and Passport. However, we were not able to identify such requirements specified in the contract. We further inquired with Passport about potential contractual obligations, and requested evidence that DMS had provided authority to UHC to administer safety-net payments. We received the following response:

> *"The method used to calculate safety-net payments is not described in the DMS contract, and to [my] knowledge DMS has not given specific approval of the methodology.*

DMS confirmed that although not specified within the contract, DMS authorized Passport to administer the safety-net payment program. DMS further confirmed that safety-net payments were appropriately considered in the development of the capitation rate ranges.

According to Passport Health Plan, Safety-Net payments are computed as follows:

> *1. The first step is to calculate "net Medicaid revenue" for the month by taking the total capitation payment received from DMS and subtracting two pass thru items which are built into the revenue rates. These two items are $15 million annual amount for hospital provider tax pass thru and $16.9 million annual amount for Urban Trauma Center funding.*
>
> *2. The total monthly amount of Safety-Net funding to be paid is calculated by taking the net revenue amount from step #1 and multiplying it by 2.42 percent then adding $333,333 ($4 million annual amount). The additional $4 million has been paid since 2008 and was added in recognition of the increasing costs associated with providing care to the Medicaid and uninsured population.*
>
> *3. The monthly total is allocated to the Safety-Net recipients based on the following percentages. The percentages were determined at the initiation of the health plan.*
>
> *- Family Health Center - 28.89 percent*
>
> *- UofL Primary Care Center - 63.82 percent*
>
> *- Park DuValle Health Center - 7.29 percent"*

Example Payment Calculation

June/May 2009 Net Capitation Revenue	$58,783,292.73
2.42% percent of revenue	1,422,556

% of safety-net fund	63.82%	$907,875	
Additional Funds:			
Monthly Amount ($4.0 million /12 months)	$333,333		
% of safety-net fund	63.82%	$212,733	
Total Safety-Net Payment for June 2009			$1,120,608

Safety-Net Payments to UPA

Approximately 64 percent of safety-net payments were paid to UofL Primary Care. Safety-net funds were used by UPA for a variety of initiatives including the following:

- Support for indigent care clinics
- Acquisition and implementation of an electronic medical record system
- Practice management infrastructure and systems
- Consultants and studies
- Funding to support the faculty practice building
- Administration and overhead
- Reimbursement and/or shared expenses with related parties
- Investment in a liability insurance carrier

The table below summarizes safety-net revenue data submitted by UPA in a response received April 4, 2012.[12] UPA's April 4, 2012 response indicates that "In regards to reserves, UPA has managed overall expenditures at a level that has increased reserves. The maintenance of adequate reserves is critical so that UPA can continue implementing essential technologies such as electronic medical record and practice management system."

State Fiscal Year				
(In Millions)	**2009**	**2010**	**2011**	**Total**
Revenue	$13.893	$19.805	$14.168	$47.865

In response to follow-up questions on April 30, 2012, UPA submitted the following: "The safety need funding that came to UPA was distributed to the various [professional service corporations] PSCs or expended on their behalf. The control over the bank account would rest with the UPA Board in the same manner as all other funds of UPA. ...All safety net proceeds have been spent either in disbursement to the providers or for certain expenditures (like improvements to the clinical space, centralized overhead, etc.). There is no balance of safety net money remaining."

[12] Reports ending 6/30/2009, 6/30/2010, and 6/30/2011

UPA informed us that all safety-net funds they received have been expended. However, other financial reports submitted by UPA suggest that a fund balance exists. In response to follow-up questions on this subject, UPA's Chief Financial Officer indicated that UPA has expenses beyond those listed on the reports submitted to Myers and Stauffer.

Question and Answer with Medical School Personnel

Who approved the decision for Family Medicine Newburg and Central Station to join the UofL Primary Care Center?

The UPA Executive Committee

What analysis was undertaken, and by whom, to assure this action would not negatively impact UofL's eligibility for participation in PSNP?

The Dept was already providing care to a significant number of passport and indigent patients at Newburg and Cardinal St. and this action would allow us to continue to do so.

What was the financial status of these three Family Medicine operations prior to and after the decision for Newburg and Central Station to join the UofL Primary Care Center?

All our clinical sites operated at a loss and continued to do so. The additional support from Passport was not nearly enough to make the remaining sites profitable and this is still the case as of today.

What analysis was undertaken and by whom to assure that closing Family Medicine ACB would not impact the ability to serve the targeted population of Medicaid, indigent, and poor patients?

We conducted a survey of our patients at the ACB that asked them if we closed this location would they be willing to relocate to our other offices, both of which are on the TARC bus service with stops in front of the building. The answers we received from patients were overwhelmingly positive. We moved each of our providers (with the exception of 2 part time) to our other locations to assure continuity, we continue to serve all Medicaid, indigent, and poor patients in the community that need care. We also hired a full time Financial Counselor and part time Social worker to assist all of these patients.

What analysis was undertaken, and by whom, to assure that closing Family Medicine ACB would not place UofL outside compliance with the eligibility criteria for participation in the Passport Safety-Net Program?

We were already taking care of Medicaid and indigent patients, and by consolidating into two locations allowed for more access to the community for these patients. Our providers were stretched thin at 3 locations and we could not continue to operate with the losses we were incurring. This action would allow the ability to consolidate our

existing providers and create more appointment slots. The analysis was done by the Executive committee and Department Administration. We continue to see all patients that we can accommodate and continue to operate with losses.

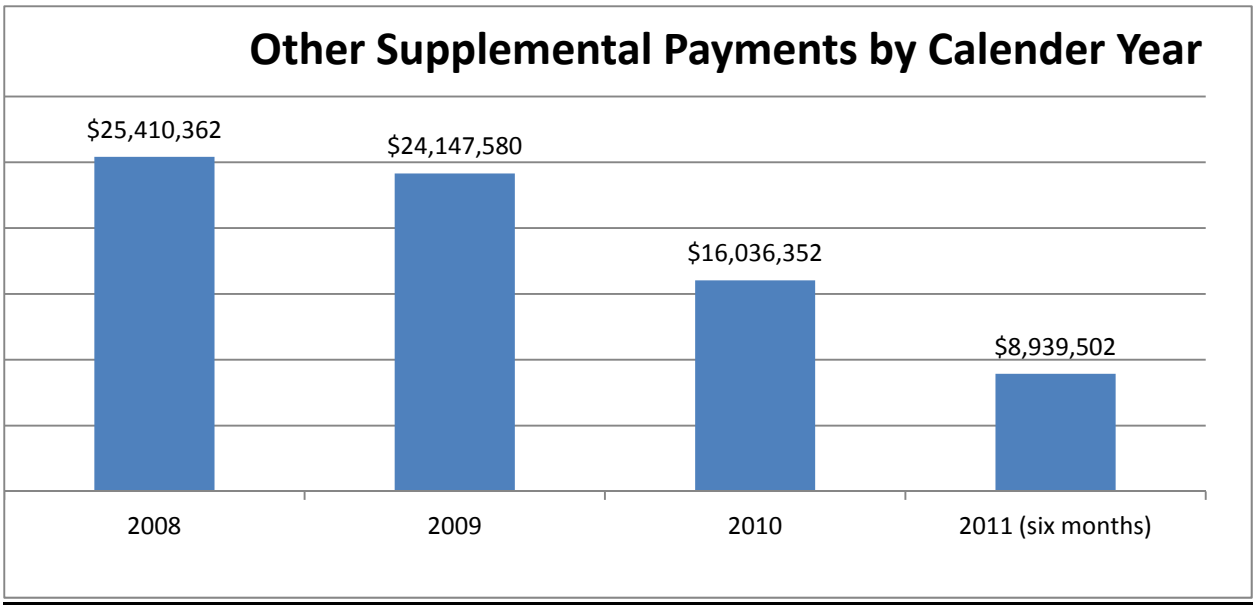
Other Non-Claim Benefit Expenditures

Passport Health Plan provided a data file that included other non-claim benefit expenditure detail from January 2008 through June 2011. The following payment programs are described in this section:

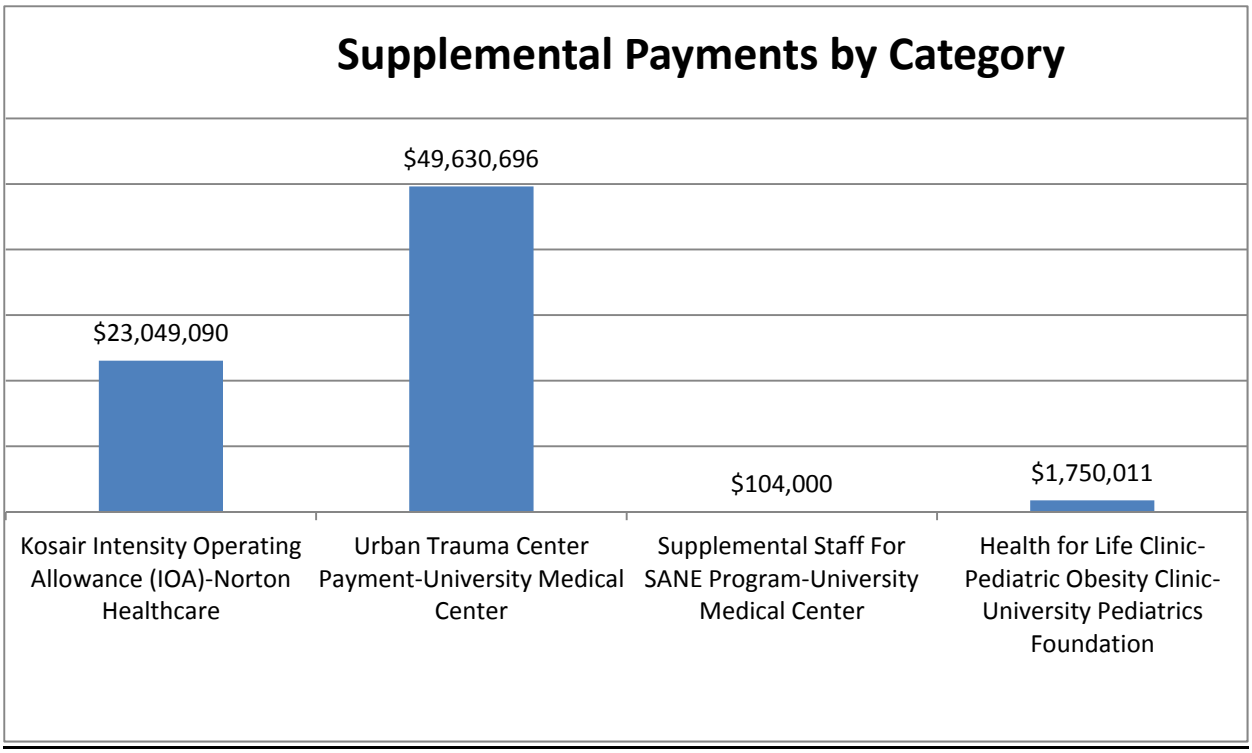
- Intensity Operating Allowance (IOA)
- Urban Trauma Center
- Healthy for Life Clinic
- Pediatric Forensic Medicine
- Sexual Assault Nursing Examiner (SANE)

Total expenditures over that span were approximately $74.5 M. Based on the payment detail, approximately $25 M in calendar year (CY) 2008, $24 M in CY 2009, and $16 M in CY 2010, Calendar year 2011 is just under $9 M based on a partial year through June 30.

Calendar Year	Kosair (IOA)-Norton Healthcare	Urban Trauma-University Medical Center	SANE-University Medical Center	Health for Life Clinic Pediatric Forensic Med-University Pediatrics Foundation	Total
2008	$9,045,014	$16,365,348	$0	$0	$25,410,362
2009	$7,282,228	$16,365,348	$0	$500,004	$24,147,580
2010	$6,721,848	$8,450,000	$52,000	$812,504	$16,036,352
2011 (six months)	$0	$8,450,000	$52,000	$437,502	$8,939,502
TOTAL	**$23,049,090**	**$49,630,696**	**$104,000**	**$1,750,011**	**$74,533,797**

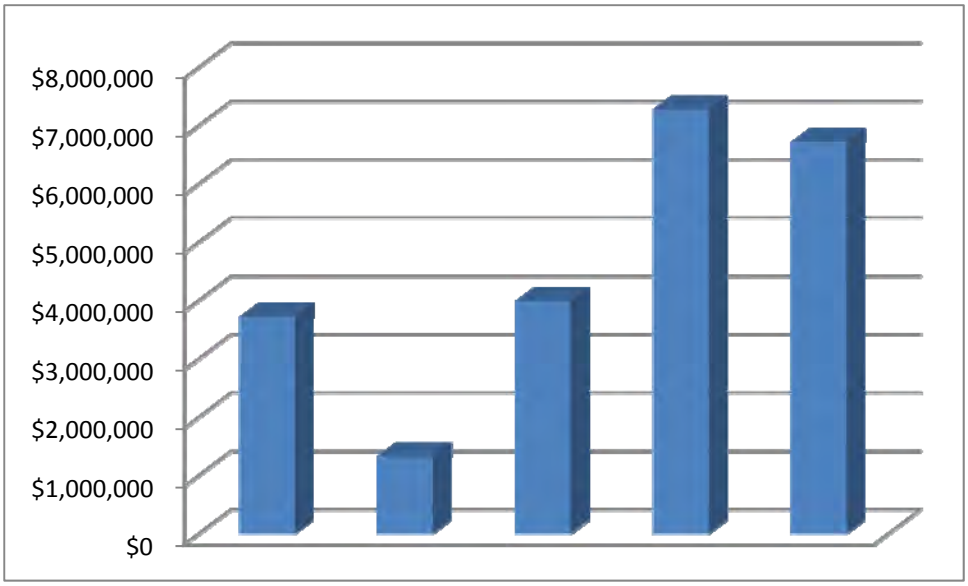


Payee	Expenditures	Claims	Minimum	Maximum	Average
Norton Healthcare (IOA)	$23,049,090	5	$1,330,852	$7,282,228	$4,609,818
UMC (Urban Trauma and SANE)	$49,734,696	17	$52,000	$16,365,348	$2,925,570
University Pediatrics (Health for Life)	$1,750,011	50	$20,833	$83,334	$35,000
TOTAL	**$74,533,797**	**72**	**$20,833**	**$16,365,348**	**$1,035,192**



Intensity Operating Allowance (IOA)

Between 2008 and 2011, IOA expenditures were approximately $23 million. All IOA payments were made to one eligible facility: Kosair Children's Hospital. Five payments were made between February 2008 and September 2010.



Passport provided the following information in regards to the IOA calculation.

> *"The Kosair IOA calculation is not described in Passport's contract with DMS. However, DMS has accepted the methodology because Norton uses the same methodology when preparing the Kosair IOA calculation that goes to DMS covering Kosair's claims for Medicaid members outside of Region 3. The IOA calculation is prepared on a calendar year basis. Passport provides to Norton a complete listing of all claims paid to Kosair Children's Hospital during the reporting period. Using this claims data, Norton completes a Medicare/Medicaid Cost Report (CMS Form 2552-96). The resultant Program Cost figure is compared to payments received by Norton related to these Kosair claims (both "claim specific" payments and any lump-sum payments made related to GME and/or rate changes). Any amount by which cost exceeds payments will be deemed a shortfall and eligible for an IOA payment from Passport."*

Urban Trauma Center (UTC)

According to 907 KAR 10:825, Urban Trauma Center payments are permitted for a "hospital that qualifies as an urban trauma center hospital" in an amount that is based on the state matching contribution. The distribution of a payment is based on a hospital's proportion of Medicaid patient days to total Medicaid patient days for hospitals that qualify as an Urban Trauma Center that are prospectively determined with an end of the year settlement and that "is consistent with the requirements of the UPL."

University Medical Center (UMC) was the only entity that received the Urban Trauma Center payment. For 2008 and 2009, the annual paid amount for this program was $16,365,348. The 2009 payment was made on August 20, 2009, and represented the only payment for that year. Beginning in July 2010, UMC began receiving monthly payments of $1,408,333. Based on the information that was submitted by PHP to support these payment amounts, we are unable to confirm that the payment amounts were correctly computed. We requested further clarification from Passport and received the following response:

> *"The University Medical Center (UMC) urban trauma center payment is a "pass through" payment included in Passport's contract with DMS. DMS builds a specific amount into our rates and Passport in turn pays out that specific amount to UMC. The payment amount is negotiated between UMC and DMS; Passport staff is not involved in these negotiations, therefore we have no knowledge of how the amount is calculated. The calculation is not described in Passport's contract with DMS. However, DMS does approve the amount as part of their negotiation with UMC."*

DMS confirmed that that the UTC payment is a "pass through" payment.

Healthy for Life Clinic / Pediatric Forensic Medicine

Per UofL website "The program [Healthy for Life], which opened this summer [2009] in newly renovated space donated by Kosair Children's Hospital, includes examination rooms, a counseling center, a group therapy space and a play center with treadmills, exercise bikes and other active gear.

The clinic also includes a teaching kitchen where staff members "offer cooking demonstrations, healthy-meal planning lessons and taste tests for parents and kids…. Passport Health Plan — believes in it enough to have provided $500,000 in essential start-up funding. As a result, all clinical services are free to any child covered by Passport."[13]

According to a UofL website, "Pediatric evaluations are restricted to cases of suspected physical abuse, neglect and pediatric condition falsification (Munchausen's syndrome by proxy). The program utilizes the services of five forensic pathologists, one forensic pediatrician, one emergency medicine physician, three forensic nurses and has consultative arrangements with pediatric radiology and forensic odontology.[14]"

Payments in these categories totaled $1.75 million, and were made over a three-year period. The payee for all payments was University Pediatrics Foundation, Incorporated.

For 2009, PHP made 12 monthly payments totaling approximately $500,000. Payments were listed as "Healthy for Life Clinic". In 2010, 24 payments were made totaling approximately $812,504. Payments listed as "pediatric forensic medicine" were made in increments of $20,833. Payments listed as "Healthy for Life Clinic" were made in installments of $41,667. In 2011, PHP made 14 payments, seven listed for "Healthy for Life Clinic" and seven for "pediatric forensic medicine". Payments in 2011 totaled approximately $437,502.

Neither program was described in the contract with DMS. We were informed by PHP that the payment methodologies/amounts were installments totaling an amount agreed upon by health plan executives. DMS did not expressly authorize payments in this program; however DMS was aware that the payments were made.

Sexual Assault Nursing Examiner (SANE)

The SANE program uses certified nurses to collect forensic evidence from sexual assault victims. University Medical Center was the sole recipient of these payments and was paid $52,000 in each year 2010 and 2011. We received an explanation from Robert Barbier, Senior VP and CFO of University Medical Center:

> "*In the hospital emergency room, SANE nurses collect forensic evidence from sexual assault victims and provide it to Metro prosecutors to*

[13] https://louisville.edu/medschool/magazine/summer09/cover/healthy\
[14] http://www.uoflphysicians.com/PhysiciansDirectory/DirectoryDetail/tabid/55/Default.aspx?id=42

support in the prosecution of alleged perpetrators in the Jefferson County area. Passport financially supports pediatricians doing similar work elsewhere in the city. Based on the understanding that Passport supported similar medical work in the area, the chairperson of the emergency medicine department requested support for the cost of the on call nursing staff needed to support the SANE program".

University Health Care, Inc. minutes from July 28, 2010 requested and authorized SANE Program payments. An excerpt of those minutes is as follows:

"Dr. Danzl made a funding request for University Hospital's SANE (Sexual Assault Nurse Examiners) Program to cover the last six months of 2010 in the amount of $52,000. He reported that 30% of the participants are Passport members and 48% are uninsured. Discussion followed.

Action: The Committee recommended for approval with six-month request of $52,000 for University Hospital's SANE Program as presented with no changes to the July-December 2010 six-month Financial Plan."

√ Observations, Findings or Recommendations Related to GME, ME, Safety-Net and Other Non Claim Benefit Supplemental Payments

1) Provisions of the UHC contract require that "in establishing payments for teaching hospitals in its Contractor's Network, the Contractor shall recognize costs for graduate medical education, including adjustments required by KRS 205.565 and 907 KAR 10:825." A specific methodology for computing GME payments is included at 907 KAR 10:825. It does not appear that the health plan is computing GME payments in accordance with 907 KAR 10:825, which requires cost data from the facility to be considered. During meetings with health plan management, we asked for an explanation on how the then current methodology was determined. They described that there was an agreed upon aggregate payment amount that was determined in 1997. A distribution formula was then developed by an actuarial consultant that achieved the desired payment level for the three eligible facilities.

2) The GME distribution formula developed by the plan's consultant has been used since it was originally developed, with only minor adjustment. According to the health plan management, there have been adjustments to the original calculation methodology. "The first is to index the payments to increases in UHC's revenue pmpm. The second is to pay all facilities at the same rate per resident." All three facilities now use the Norton rate.

3) During on-site activities at PHP, we inquired whether the health plan had ever requested authorization from DMS regarding the methodology used to compute payments. UHC management indicated that they "never walked through the calculations with DMS." DMS confirmed that it had not been advised of the approach used by PHP. PHP should work with DMS to adjust the GME formula, if such an adjustment is determined to be necessary.

4) Medical education payments to the UofL Research Foundation were restructured effective June 30, 2011. We understand that the restructured program is based on an Upper Payment Limit methodology. Furthermore, we understand that PHP's involvement in the new program is limited, in that payments made to the Foundation are computed outside of PHP's domain, and funds of equal amounts are added to PHP's capitation payments from DMS.

5) UHC reported that ME payments were included as medical expenses in the databook used to compute the capitation rate ranges. Because this payment program is not addressed by the contract between DMS and UHC, it appears that it is a discretionary expenditure. DMS has confirmed that these are permissible expenditures.

6) UHC personnel reported that it is their understanding that the payments were used to "support medical education in general," and thus, there was no agreement between UHC and the UofL Research Foundation on how UHC expected the funds to be used. Even if it were agreed between the two parties that the funds were to "support medical education in general," the terms should be memorialized in documentation maintained by both parties. Since ME payments have been discontinued, our observations regarding ME payments only apply to periods prior to the discontinuation of the ME payments. However, we believe it is appropriate for UHC to apply this concept to any discretionary payments or payment programs authorized in the future.

7) During a January 18, 2012, interview with medical school personnel, we requested information concerning how ME payments have been used. We understand that under a "clinic teaching agreement," all revenues received by the medical school are to be assigned to the UPA. Medical school personnel indicated that a portion of the ME funds (approximately $2 million annually) are allocated to various departments, with the remaining deposited into an account controlled by the Executive Vice President for Health Affairs (EVPHA). This position is currently held by Dr. David Dunn, who assumed his responsibilities as of July 1, 2011.

8) Over the course of several interviews and discussions with medical school representatives, we were informed that the University Board of Trustees (UBT) has oversight responsibilities for all University budgets and all approved functions. Authority of the UBT is delegated to department chairs, administrators, and executives (i.e., Agents of the UBT) within the University. Medical school personnel indicated that there are multiple accountability and transparency controls at the University, including annual audits of its consolidated financial statements, internal audit functions, ongoing compliance related activities, and other external functions. We reviewed the materials on The UofL Audit Services Web site (see http://louisville.edu/audit/) indicates "Audit Services reviews and evaluates the adequacy and effectiveness of the systems of internal control provided by the University and its affiliated corporations." Based on the potential for public interest issues related to the disposition of non-claim specific financial transactions with Passport, we recommend that the UofL Research Foundation consider a review by Audit Services to assess the risks and control environment related to such payments and to confirm that there is the requisite level of transparency, accountability, and oversight of these funds.

9) The UofL Executive Vice President for Health Affairs oversees the account where medical education funds are deposited. The University provided an overview of revenue and expenses from that account between 2004 and 2010. Based on funds deposited and expended for that period (i.e., irrespective of the beginning balance for 2004), the documentation from the University indicates a surplus of approximately $6 million. We requested the beginning balance for 2004, as well audit trail detail through 2011 for 14 of 40 cost centers. Of the 14 cost centers

selected for review, staffing costs were seen regularly either in recruitment or in reimbursement for salary. Of note, in SFY's 08 - SFY 2011, the amount shown for the Health Affairs Office has grown from $361,335 to $2,054,140 where as reimbursement for the Medicare Compliance Office and Privacy Office was discontinued during those years. In cost center "Anatomy - Fac recruitment" there was a payment of greater than $1.1 million made in SFY 2011 that was outside of the period supported by back-up documentation, and is much higher than prior payments for recruitment activities.

10) UHC reported that safety-net payments are included as medical expenses in the databook used to compute the capitation rate ranges. Because this payment program is not addressed by the contract, it is a discretionary expenditure. DMS has confirmed that these are permissible expenditures.

11) UHC personnel reported that it is their understanding that the safety-net payments were used to offset the cost of indigent care, and thus, there was no agreement between UHC and the eligible entities on how the funds were to be used. Even if it were agreed that funds were be directed to “indigent care” in general, we believe the terms should be memorialized in documentation maintained by both parties.

12) It is our understanding that Safety-Net payments to the UofL Primary Care Center have been restructured effective June 30, 2011. We understand that the restructured payments result in a net-decrease to UofL Primary Care.

13) Safety-net payments made to the UofL Primary Care Center were retained by the groups (i.e., UPA) that comprise the physician faculty at the UofL. UPA is the entity that holds the master lease with the University Faculty Office Building LLC. Please refer to the Appendix for additional information.

14) There appears to be limited availability of documentation from PHP for certain non-claim benefit expenditures. Payment programs for Healthy for Life Clinics, Pediatric Forensic Medicine, and the SANE programs are not described in the contract with the Department. Therefore, these payments should be classified as discretionary expenditures. DMS has confirmed that these are permissible expenditures.

15) All payment programs should be documented in contracts, provider manuals, regulations, and/or the Medicaid State Plan.

16) Policy and decision-makers from the Executive and Legislative branches of the Commonwealth may wish to consider how scarce supplemental funds should be leveraged in the community. Absent clearly defined parameters, receiving entities will continue to use such funds according to the prudence of their organization unless otherwise directed by federal statutes or regulations, Revised Statutes or Administrative Regulation of the Commonwealth.

17) The documentation submitted by PHP to support the non-claim payment calculations is insufficient to document that payments made are in compliance with applicable guiding requirements. We recommend that all calculation components cite the authorization/guiding parameters. We found certain factors used within analyses that did not contain or reference any source information (e.g., eligibility categories, etc).

18) Because UHC makes payments to eligible providers under the Intensity Operating Allowance and the Urban Trauma Center programs, they should maintain supporting documentation. Supporting documentation should include calculations, and DMS authorization. PHP should maintain such documentation, and update on a routine basis to support any payments made to providers. Furthermore, any such payments should be fully documented in the contract with DMS.

Objective 2A: Passport's Lines of Business/Cost Allocation Analysis

The objectives of this analysis include the following components:

Examine the lines of business conducted by AmeriHealth Mercy Health Plan and other Passport subcontractors. Address, at minimum, the following:

a. Cost allocation of shared resources (i.e. personnel, facility) and the methodology for determining those allocations.

b. Reporting of cost allocations by subcontractors to Passport.

c. Passport's methodology for determining reasonableness of cost allocations.

d. Passport's policies and procedures for monitoring cost allocations during the term of subcontracts.

e. Timeliness of claims paid by AmeriHealth Mercy Health Plan and other subcontractors. The frequency of claims paid untimely and interest incurred in such cases.

f. Appropriateness of expenditures as related to contract responsibilities.

Cost Allocations

Myers and Stauffer requested information regarding the cost allocation methodology from Passport and each of its subcontractors. Only AMHP submitted documentation relative to this request. Upon inspection of that document, which is included in this report as Exhibit E, it appears that the methodology described in the documentation submitted by AMHP appears to be the cost allocation methodology for administration and overhead attributable to the AMHP lines of business (i.e., does not include allocations for the PHP line of business). Although PHP contracted with AMHP and delegated authority for financial reporting and the accumulation of data required in developing Passport capitation rate ranges, it is not clear to us whether AMHP used a similar methodology in its preparation of the financial reporting for PHP. Therefore, we are unable at this time to provide analysis relative to methodology or reasonableness of cost allocations.

Timeliness of Claims Paid by AmeriHealth Mercy Health Plan

Section 3.4 of the contract between DMS and UHC includes the following requirement regarding payment of provider claims:

> In accordance with the Balanced Budget Act (BBA) Section 4708, the Contractor shall implement claims payment procedures that ensure 90% of all provider claims are paid or denied within thirty (30) days of the date of receipt of such claims and that 99% of all claims are processed within ninety (90) days of the date of receipt of such claims following the date of such claims, properly documented and sufficient for processing, are submitted. In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended.

Included in KRS 304.17A-700, the definition of a "clean" claim means:

> (3) …a properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following applicable form:
>
> (a) A clean claim from an institutional provider shall consist of:
>
> 1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;
>
> 2. Entries stated as mandatory by the NUBC; and
>
> 3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.
>
> (b) A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.
>
> (c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.
>
> (d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs…

AMHP provided a number of documents relative to the adjudication of claims on behalf of Passport Health Plan. These documents included a list of exception codes which are indicative of a claim deemed "unclean" (See Exhibit F). AMHP also provided a document to describe the adjudication of claims through its claims processing system, FACETS. This document, Exhibit G, provides a high level look at the process by which claims are moved through the system from receipt to final adjudication. Finally AMHP provided a monthly summary of timely paid claims and any applicable interest paid for claims paid during the examination window. This summary is shown in the table below:

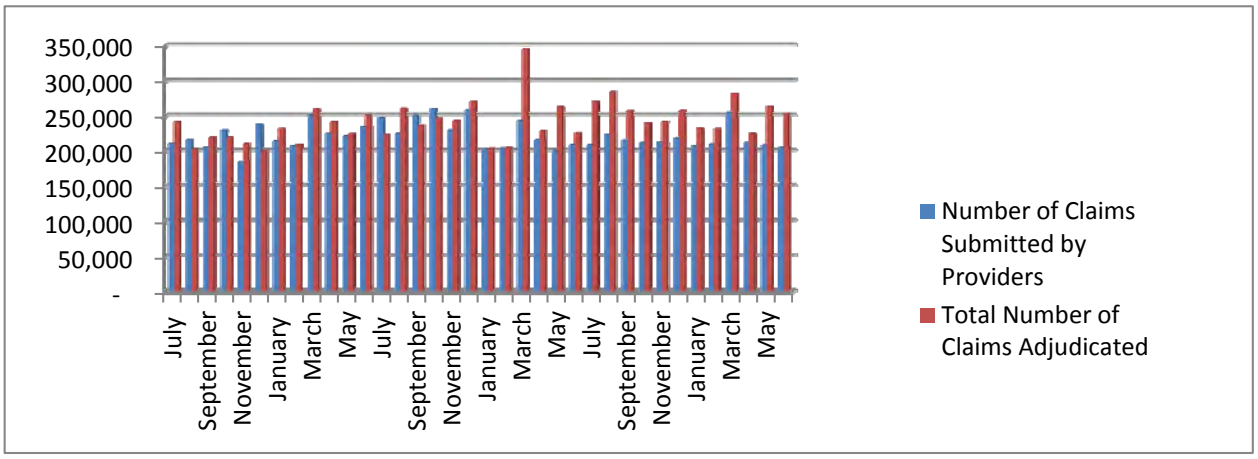
Table 2A-1: Summary of Claims Statistics and Interest Paid

Year	Month	Number of Claims Submitted by Providers	Number of Clean Claims Submitted by Providers[1]	Total Number of Claims Adjudicated	Total Interest Paid on Claims Paid Late
2008	July	210,645		241,315	$403.87
2008	August	215,886		202,634	$1,272.09
2008	September	205,622		219,267	$1,415.71
2008	October	229,690		219,225	$3,313.94
2008	November	184,362		210,260	$5,043.36
2008	December	237,868		199,658	$546.05
2009	January	214,671		231,702	$526.96
2009	February	207,482		209,289	$572.07
2009	March	251,181		259,514	$911.77
2009	April	224,760		241,291	$372.38
2009	May	221,419		224,349	$552.41
2009	June	234,172		251,033	$290.14
2009	July	247,402		223,729	$1,502.47
2009	August	225,022		260,409	$852.49
2009	September	249,702		236,625	$4,788.26
2009	October	260,050		246,129	$2,752.91
2009	November	229,600		242,844	$2,577.03
2009	December	258,428		270,132	$2,783.76
2010	January	202,410		203,997	$2,924.55
2010	February	204,195		205,362	$9,364.30

Year	Month	Number of Claims Submitted by Providers	Number of Clean Claims Submitted by Providers[1]	Total Number of Claims Adjudicated	Total Interest Paid on Claims Paid Late
2010	March	242,771		345,255	$5,818.45
2010	April	215,591		228,545	$1,096.40
2010	May	199,167		263,060	$9,650.60
2010	June	208,657		225,886	$4,719.25
2010	July	208,408		270,837	$11,249.61
2010	August	223,273		284,310	$4,790.99
2010	September	215,218		257,154	$1,181.97
2010	October	211,740		239,995	$1,500.05
2010	November	212,148		241,782	$2,378.10
2010	December	218,491		257,369	$1,913.85
2011	January	207,327		232,483	$795.55
2011	February	209,733		231,621	$873.68
2011	March	254,984		281,823	$634.60
2011	April	211,766		225,115	$870.61
2011	May	208,078		263,806	$1,834.76
2011	June	205,385		253,306	$5,156.50
TOTAL					**$97,231.49**

[1] *Information regarding the number of clean claims submitted by providers each month was not provided by AMHP/PHP.*

Chart 2A-1: Summary of Claims Submitted and Adjudicated



In reviewing the information provided by AMHP, we noted that on average:

- Passport providers submitted 221,314 claims for payment each month,
- AMHP adjudicated 241,698 claims, and
- PHP paid approximately $2,700 per month in interest on late paid claims.

The trend displayed of adjudicating, on average, approximately nine (9) percent more claims than the number of claims reported as being submitted by providers may indicate an issue with the data provided.

We noted that a significantly higher number of claims were adjudicated in March 2010 than in other months. Because there is no corresponding increase in the number of claims submitted prior to that time nor is there a comparable increase in the interest paid on late claims, this could also be indicative of an issue in the data.

We requested that PHP describe the requirements for timeliness of claims payments and the payment of interest for untimely payments, as applicable. We also requested that they provide reports to illustrate payment timeliness and interest paid by year for SFYs 2009, 2010, and 2011, including all benefit subcontractors. Passport did not provide any narrative but provided a table detailing interest paid on claims by calendar year which agrees with the interest paid reported by AMHP in Table 1, above. It is not clear based on the information submitted to what type of claims or which subcontractor the interest payments relate.

It is important to note that the information provided by AMHP/PHP above has not been independently validated. In addition, insufficient information was provided regarding the submission of clean claims to provide the engagement team with an understanding of

the level of claim rejections occurring prior to the adjudication process. AMHP did not provide information relative to the claims that did not meet the prompt pay requirements in order for us to analyze the appropriateness and accuracy of the interest payments on those claims.

No additional information related to the timeliness of claims paid and interest paid on claims was submitted by the other Passport subcontractors, including Block Vision, PerformRX, AmeriHealth HMO, Doral Dental or MCNA. Therefore, we are unable to provide analysis or findings relative to claims and interest payments for those subcontractors.

Appropriateness of Expenditures

With the exception of the cost allocation methodology document provided by AMHP as described above, no other documentation relative to the allocation of expenditures across the Passport lines of business was provided. We are, therefore, unable to provide analysis that would enable us to offer conclusions and responses to the objectives, including an evaluation to determine that the expenditures reported by Passport for its Medicaid line of business are reasonable and appropriate. During the period addressed by the examination window, the health plan had another line of business, the Passport Advantage delivery system. Based on the accounting procedures that would be expected in a multiple delivery system environment, we would have expected to receive a comprehensive cost allocation plan. Passport management informed us that the Passport Advantage line of business was discontinued in December 2011**.**

√ Observations, Findings or Recommendations Related to Passport's Lines of Business/Cost Allocation Analysis

1) Cost allocation plans were not provided that would describe and illustrate how Passport ensures the accuracy of expenditures included in its financial reporting documents or in the data used to prepare capitation rate ranges. Based on the unavailability of such information, we believe that there is an elevated risk that expenses have not been properly reported.

2) Concerns were noted with the potential accuracy of the summary of claims submitted and adjudicated by AMHP. Specifically, the ratio of claims submitted to claims adjudicated and the accuracy of interest payments.

3) No claims payment timeliness data was provided by other Passport subcontractors.

OBJECTIVE 2B: BEST PRACTICES

To assess the best practices in the Medicaid lines of business of the subcontractors to determine, at minimum, the following:

a) The level of coordination of best practices between the various lines of business,

b) Passport's method of allocating costs/savings that results from the best practices,

c) The effectiveness of communication to the Department for Medicaid Services regarding costs/savings experiences through best practices of subcontractors,

d) The degree of leverage gained by the Department for Medicaid Services due to knowledge of best practices of subcontractors.

Coordination and Communication

Passport has a policy, in effect since December 1998[15], named "Oversight of Delegated Activity", which we were able to analyze for applicability of oversight and communication with their subcontractors and vendors. After review of the policy, we found that PHP has identified several areas in which they determined reports should be submitted by each "delegated relationship[16]", the need for an annual evaluation and corrective actions, if needed. However, the delegated items listed in policy do not appear to cover all the delegated relationships utilized during the examination window, July 1, 2008 through June 30, 2011. The items covered in the policy are Quality Improvement, Utilization Management, Credentialing, Member Services, Provider Access Standards, and Operational Standards. Operational Standards includes claim processing, call center response, and encounter data submissions. The policy has a note in the Review/ Revision Dates section which states "Originally coded as QI 5.01". The policy contents would align with policy on "Quality", and appears to not be relevant to financial reporting.

One area that does not appear to be covered by policy is Financial Reporting. The responsibility for financial reporting was delegated to AMHP during the examination

[15] Based on the date of the policy, we infer that its development pre-dated implementation of the PHP integrated business model. The uniqueness of such a model would typically require modification or refinement of policies impacting coordination and communication. The absence of such refinements may be an indicator of the entity's reliance and usage of the policy.
[16] The terms "delegated relationships" or "delegated vendor" are common terms in the health care/insurance industry that carry a similar meaning as "subcontractor". However, it should be noted that such terms may carry different meanings in the legal or regulatory industry.

window. Based on the data and documentation submitted, it does not appear that PHP has a mechanism or policy to monitor financial reporting.

Myers and Stauffer interviewed a number of individuals at PHP and AMHP. During the interview process, personnel from AMHP discussed the transition that was then underway to transfer to UHC some of the duties and responsibilities then currently performed by AMHP (i.e., in the PHP integrated model in place since the health plan's inception), pursuant to the model developed in response to Governor Beshear's CAP. Information obtained during our interviews suggested that the responsibility of financial reporting would be transitioned to PHP in the first quarter of 2012.

As part of the oversight process, the health plan policy should contain a process or procedure to identify the frequency with which the parties will communicate regarding operating status, as well as document the steps to be taken to identify issues, report, and develop resolutions. The PHP oversight policy does not appear to include a communication plan or issue resolution plan.

We asked Passport to provide a description of their communication process with their subcontractors. We received the following response:

> Passport assigns a Delegation Oversight Manager to all subcontractors who coordinate and communicate all delegate oversight activities with the delegate's assigned Account Manager. Passport's Operations and Finance departments communicate, as needed, for day-to-day operational needs with their designated contact personnel within each subcontractor. Communication between the delegate and Passport are accomplished through the use of facsimile, telephonic and electronic (secure email, FTP) means. See Attached File for specific Communication and Implementation of DMS Benefit and Reimbursement Changes Related to Dental, Vision and Family Planning Services.

The policy which is referenced in their response describes their change process during the audit window related to benefit and reimbursement modifications, established by DMS, and related only to Dental, Vision, and Family Planning subcontractors. The policy does not address other subcontractors and it is not clear if a policy exists for the other subcontractors.

Best Practices

We requested that Passport describe how cost savings achieved by PHP or any of its subcontractors translated into cost savings realized by DMS, including a description of specific activities that resulted in cost savings and how those savings were reflected in the payments to PHP from DMS.

> The data book prepared annually by PwC is based in large part on Passport's historical claims experience. To prepare the data book, DMS provides to PwC, Passport's claims encounter data for a recent two year

period. To the extent that Passport has decreased claims costs either through lower utilization or reductions in reimbursement rates, these cost savings would be reflected in the claims encounter data used by PwC to prepare the data book. Since the capitation rates that DMS pays Passport are reflective of the costs included in the data book, any cost savings generated by Passport are ultimately reflected in lower capitation rates paid to Passport and thus lower costs incurred by the state.

Myers and Stauffer also utilized a number of other sources to identify industry practices for administration and financial management of managed care plans. These sources include the following reports:

- Regulation for Uniform Definitions and Standardized Methodologies for Calculation of Medical Loss Ratio for Plan Years 2011, 2012, and 2013 per Section 2718(b) of the Public Health Services Act National Association of Insurance Commissioners (NAIC) October 2010[17]

- Administrative Expenses of Health Plans Douglas Sherlock, 2009[18]

- Medicaid Risk-based Managed Care: Analysis of Financial Results 2009 Jeremy D. Palmer, FSA, MAAA, Milliman Insight, July 2010[19]

- A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey Kathleen Gifford, Vernon Smith, Dyke Snipes Health Management Associates and Julia Paradise Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, September 2011[20]

One of the most important financial metrics used to report financial performance of a health plan is the Medical Loss Ratio (MLR). MLR measures the portion of revenue received by a health plan that was used for the reimbursement of medical expenses for enrolled members.

The Sherlock Company published a report entitled “Administrative Expenses in Health Plans” in 2009, which used health plan administrative expenses data from 2007 to develop administrative expense benchmarks. They reported that the overall administrative expenses are not as high among commercial health plans as previously estimated and comparisons to [Medicaid][21] may be overstated. Sherlock expressed that

[17] Link to NAIC model regulation: http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf
[18] Link to Sherlock Report: https://www.bcbsnd.com/docs/blueinsight/Administrative-Expenses-Sherlock-Report.pdf
[19] Link to Milliman Insight Report: http://publications.milliman.com/research/health-rr/pdfs/medicaid-risk-based-managed.pdf
[20] Link to Kaiser/ HMA Report: http://www.healthmanagement.com/news_details.asp?newsarticleid=447
[21] Because of the similarities between the Medicare and Medicaid programs we have extended the Sherlock Report’s commentary regarding the Medicare program to the Medicaid program.

administrative expenses for commercial health plans and [Medicaid] are not directly comparable due to differences in marketing, wellness and care coordination plans.

The table below is based on Figures 2 and 3 of the Sherlock Report related to administrative expenses, which includes pharmacy and mental health expenses, but excludes business taxes. Small group costs were calculated with Blue Cross Blue Shield data from 2007. The mean, or average, for all commercial plans is 9.7 percent. Although 2007 is outside of the analyzed period, based on a Loss Ratio spreadsheet Passport provided to Myers and Stauffer, we see the average Passport administrative expenses for 2008 were 11.8 percent and averaged 5.4 percent in 2011.

Table 2B-1: Total Administrative Expenses (Sherlock, 2009)

Total Costs Commercial Plans			Total Costs Small Group		
Mean	Median	Weighted	Mean	Median	Weighted
9.71%	9.70%	9.18%	12.54%	11.05%	11.12%

PricewaterhouseCoopers, LLP (PwC) provided capitation rate range development services for the Department for Medicaid Service during the examination window. As a part of that process, PwC explained that they conduct a test of reasonableness of PHP's administrative expenses compared to other Medicaid health plans. During an interview with PwC[22], they indicated that they have not observed any material differences between PHP administrative expenses and those experienced by other health plans. In fact, PwC noted that PHP administrative costs as a percentage of revenue "have been on the low side" over the last several years.

The Sherlock Report includes a breakdown of administrative categories and expenses that are typically found in "Private Plans." As a simple comparison, we added expenses that should be experienced by Passport Health Plan based on the business model and contractual obligations. *Please note that for purposes of this comparison we considered anecdotal information that suggested PHP should have expenses in these areas. We did not conduct an analysis of PHP administrative expenses for this comparison.*

Table 2: Administrative Expense Categorical Comparison (Sherlock, 2009)

Administrative Functions / Cost Categories[23]	Private Plans	PHP
Enrollment/ Membership	√	√
Customer Service (*i.e., Member Services for PHP*)	√	√

[22] Interview with Peter Davidson, September 28, 2011
[23] Categories as described in Sherlock Report, 2009. We made some minor changes to add clarifying detail.

Administrative Functions / Cost Categories[23]	Private Plans	PHP
Provider Relations Services	√	√
Provider Network Management and Services	√	√
Claim, EDI, Encounter Capture and Adjudication	√	√
Information Systems as Expensed	√	√
Actuarial / Auditing Costs	√	√
Provider Contracting	√	√
Provider Credentialing (Performed in house unless a UPA provider, UPA credentials its own providers at no cost to UHC)	√	Provided at No Cost
Printing, Mailroom, Imaging (converting paper to electronic)	√	√
Corporate Funded Services (e.g., security, equipment)	√	√
Purchasing	√	√
Provider Rate Negotiations	√	√
Legal Services	√	√
Marketing, Including Advertising and Promotion	√	Limited by Contract
Medical Management/ Quality Assurance	√	Limited by Contract
Care Coordination / Disease Management	√	√
Wellness Programs and Activities	√	Limited by Contract and/or Population Differences
Finance and Accounting	√	√
Corporate Administrative Services	√	√
Corporate Executive/ Governance	√	√
Association Dues and License/ Filing Fees	√	Limited

Passport has certain administrative expenses that may not be comparable to their commercial plan counterparts, such as marketing activities that may be limited by contract. Distinct differences in member populations or contractual responsibilities could be a cost factor for certain activities such as wellness programs and community

outreach. While there are certain differences that can be expected between commercial and public programs, there would appear to be more similarities. Additionally, public programs likely have more costs associated with compliance and the administrative concerns indicative of government sponsored programs.

The Medicare Payment Advisory Commission (MedPAC) has indicated that low administrative costs are not necessarily beneficial. Lower administrative costs can lead to significant impacts on the detection of fraud, waste, and abuse, utilization management, and programs that promote wellness among beneficiaries (Sherlock, 2009). Specifically MedPAC indicates[24]:

> Any analysis that considers administrative expenses must also consider the efficiency and effectiveness of the benefit expenditures they oversee. Administrative activities contribute to the value of health benefits in a variety of ways, but it is not always clear how Medicare [Medicaid] and the private sector compare under various metrics. For example, CMS estimates that about $9.8 billion in erroneous payments were made in the fee-for-service program in 2007, a figure more than double what CMS spent for claims processing and review activities (CMS 2008a). (Sherlock, 2009)

The National Association of Insurance Commissioners (NAIC) was tasked by Section 2718 (b) of the Public Health Service Act to develop uniform definitions and standardized methodologies for calculating the MLR for plan years 2011, 2012, and 2013. The Public Health Service Act allows for an MLR rebate beginning in plan year 2014 based on the previous three years' calculations. The NAIC submitted their recommendations for a model regulation to the Department of Health and Human Services (HHS) in October 2010. The recommendations from the NAIC are included in Exhibit H of this report.

The model regulation updates the calculation for MLR that includes a "credibility adjustment", which is an adjustment to account for variations in the claims experience for smaller health plans. There are also deductions for federal and state taxes, licensing and regulatory fees, and expenses to improve health care quality. Since the contract between DMS and PHP requires a quarterly report of MLR, this new methodology for calculating MLR will need careful monitoring to ensure the calculations are an accurate reflection of the health plan's qualifying medical expenses, especially once the rebate period begins. The transition from AMHP to PHP for recording medical expenses and other financial reporting responsibilities creates an elevated need for additional oversight of the MLR calculation.

[24] Comments made by MedPAC were related to the Medicare program. For purposes of this analysis, we have extended their rationale to the Medicaid program as well, based on MedPAC's rationale is not impacted by differences in programs or patient populations but rather administrative spending characteristics.

As part of the data and documentation requests for the examination, we received a spreadsheet from PHP illustrating the MLR for each month; however, we were not provided with the supporting detail that would permit confirmation of the calculations.

Milliman Insight published a report in July 2010 entitled "Medicaid Risk-based Managed Care: Analysis of Financial Results for 2009". The purpose of this report was to provide benchmarks for Medicaid health plans based on 2009 data. It lists the MLR, Administrative Loss Ratio (ALR) and other financial measurements. The report summarized the measurement of annual statements from 30 states, which represented 148 Managed Care Organizations (MCOs). The Composite Mean, or overall average, for MLR was 88.0 percent.

The Commonwealth is listed in CMS' region 4, which also includes Tennessee, Georgia, North Carolina, South Carolina, Florida, Alabama, and Mississippi. According to Milliman Insight, the average MLR for Region 4 is 87.5 percent. PHP's MLR, as provided to MSLC, is listed by month for calendar years 2008, 2009, 2010, and 2011 through July. For calendar year 2009, which compares to the benchmark information in the Milliman report, PHP's average MLR was 86.5 percent, which is comparable to the Region 4 average. PHP's reported average MLR in calendar years 2008 and 2010 was 87.5 percent and 92.4 percent, respectively. For this phase of the examination, we do not have sufficient detail that would enable us to comment on the increase in the MLR over the period being analyzed. However, information provided during interviews with health plan personnel as well as with the Department's actuary suggests that MLR increases may be a function of intended adjustments to the actuarial rate ranges, or decreases in Medicaid revenue. Generally, as the MLR approaches 100 percent, the health plan could be considered to be in financial distress as the administrative expenses may not trend down to offset increases in medical expense.

The Kaiser Family Foundation sponsored a 50 state survey of Medicaid Directors on the use of managed care in their programs. In all but three states, there is some version of managed care operating, accounting for approximately 66 percent of Medicaid members. In the table below, some of the best practices identified in the Kaiser report are listed with an indicator to identify whether the best practice was represented in the PHP service delivery model effective during the period being analyzed. Please note that we used the PHP related responses provided to the Kaiser survey for the best practices comparison in the table below.

Table 3 – Selected Best Practices (Kaiser, 2011)

Best Practice	Represented in the PHP Service Model
MCO Licensed as a Health Maintenance Organization (HMO)	Yes
MCO Accreditation	Yes
External Appeal Process for Members	No[25]
Healthcare Effectiveness Data and Information Set (HEDIS) Performance Measures	Yes
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Required	Yes
Publicly Release Quality Reports	No
Care or Disease Management	Yes
MLR Minimum	No

Cost and Savings Allocations

We did not receive any cost allocation or savings information from PHP to determine if any of their methods or measures could be compared with general business cost allocation and savings best practices.

[25] As required by Federal Regulation, members do have access to a state fair hearing process.

Observations, Findings or Recommendations Related to Best Practices

1) It does not appear that PHP had appropriate mechanisms in place to monitor financial reporting during the period being analyzed. No documentation has been provided to suggest that monitoring of financial reporting after the transition from AmeriHealth Mercy to Passport is being considered.

2) Passport's "Oversight of Delegated Activities" policy is outdated and does not address essential components.

3) Changes to the formula for calculating MLRs for plan years 2011, 2012, and 2013 have been recommended by the NAIC. PHP has indicated that it is reviewing the NAIC guidance on the determination of administrative costs and will work to ensure PHP is consistent with DMS policy and definition of MLR.

4) Based on 2009 data, the Milliman report established an MLR benchmark for CMS Region 4, in which Kentucky is a member, at 88 percent.

5) Selected best practices from the Kaiser Report indicated areas in which there may be opportunities to reduce costs and improve member care and experience.

6) Passport did not provide any cost allocation or savings information to determine if any of their methods or measures could be compared with general business cost allocation and savings best practices.

OBJECTIVE 2C: SELECTION OF SUBCONTRACTORS

The key activities related to this task include:

Review PHP's methodology for selection of subcontractors. Including, at minimum, the following:

a. The process used to select subcontractors, use of competitive or Non-competitive methods.

b. Conflicts of interests or related party interests.

Following discussion with the Department and development of an analytical strategy designed to assess the PHP's use and selection of subcontractors, Myers and Stauffer developed a survey document to capture essential data and documentation necessary to address the objective. The survey captured information about the use of subcontractors and whether such an entity was selected based on competitive or non-competitive methods. The analyses included steps to evaluate the contract between the Department and PHP and an evaluation of PHP's responses to the survey in an attempt to understand several aspects of the subcontracting process.

Based on a risk assessment of the information provided, we conducted follow-up interviews, both on-site and by telephone; requested additional documentation to assist in our analyses; and completed an analysis of source documentation.

This report provides a list of PHP subcontractors, includes the pertinent subcontractor selection language in the contract between the Department and PHP, details the analyses and findings, and includes recommendations to improve transparency and oversight of the program.

Central to the analysis of the subcontracting process is the definition of the term "subcontractor", which is found in Section 1.1 of the Scope of Work from the contract between DMS and UHC. The definition is as follows:

> Any person or entity which contracts directly or indirectly, or otherwise agrees, to perform any function, or to support performance of any function, for the purpose of fulfilling Contractor's obligations under this Contract or the Partnership Program including, but not limited to, provision of any administrative, support, or health care services, or to provide any material in support of those services.

The contractual definition of subcontractor is broadly defined as any entity that agrees to the "provision of any administrative, support, or health care services, or to provide any material in support of those services." PHP has indicated they are working with DMS to clarify the definition of a subcontractor.

Data and documentation requests submitted to PHP and AMHP were developed based on the above contractual definition. We requested a list of subcontractors and vendors, copies of contracts and amendments, organizational charts, employee lists, timesheets and other relevant information. The health plan subsequently questioned the application of the term as used in our data and documentation requests. During follow-up meetings with the plan, both the Department and MSLC directed PHP to Section 1.1 of the contract between DMS and UHC. The Department clarified for PHP that the definition of subcontractor had not changed, referencing earlier communications between the Department and PHP, which MSLC was not a party to. Further discussion with the Department confirmed that we had correctly applied the definition. Hence, this apparent misunderstanding of the definition of the term subcontractor by the health plan may have had an adverse impact on PHP's ability to timely produce data and documentation to support the Passport Health Plan business model. We believe there is a substantial risk that supporting documentation related to the contractually defined set of subcontractors may not be available.

Identification of Passport Subcontractors – July 1, 2008 through June 30, 2011

Table 1 below includes a list of PHP subcontractors and is based on documentation and information provided by PHP, based on the entities PHP considers (or at one time has considered) to be a subcontractor. Based on documentation and interviews with PHP personnel, it appears that this list of subcontractors contains inconsistencies. Furthermore, and as described above, the list provided by PHP may not be a complete list of entities that would qualify as a subcontractor under the terms of the contract between DMS and UHC.

Table 2C-1: Passport Subcontractors

Row	Subcontractor Name	Service Period	Subcontracted Service(s)	Note(s)
1	AmeriHealth HMO Incorporated	7/1/2008-6/30/2011	Family Planning Services	
2	AmeriHealth Mercy Health Plan	7/1/2008-6/30/2011	Health Plan Administration / Management	
3	Block Vision, Inc.	7/1/2008-6/30/2011	Vision Administration Services	
4	DentaQuest (Formerly Doral)	7/1/2008-6/30/2009	Dental Administration Services	
5	Healthcare Options Incorporated	7/1/2009-6/30/2010	Unknown	In response to the survey, Passport provided a list of vendors and subcontractors that included Healthcare Options Incorporated as a Consultant to Passport for the periods July 1, 2008 through June 30, 2009 and July 1, 2010 through June 30, 2011. The list indicates that Healthcare Options Incorporated was a Subcontractor between July 1, 2009 and June 30, 2010. However, Passport did not provide a copy of a contract between Passport and Healthcare Options Incorporated for the subcontracted period and the Department indicated it did not receive a request from Passport to approve Healthcare Options Incorporated as a subcontractor. Passport later provided a separate Vendor Payments file that indicates Healthcare Options Incorporated was not a subcontractor at any point during the period between July 1, 2008 and June 30, 2011.
6	ikaSystems Corporation	7/1/2010-6/30/2011	Unknown	In response to the survey, Passport provided a list of vendors and subcontractors that included ikaSystems Corporation as a Consultant to Passport for the period July 1, 2008 through June 30, 2010. The list indicates that ikaSystems Corporation was a Subcontractor between July 1, 2010 and June 30, 2011. However, Passport did not provide a copy of the contract between Passport and ikaSystems Corporation for the subcontracted period. The Department indicated it did not receive a request from Passport to approve ikaSystems Corporation as a subcontractor. According to our interviews with Passport, no subcontract activity occurred between ikaSystems Corporation and Passport.

Table 2C-1: Passport Subcontractors

Row	Subcontractor Name	Service Period	Subcontracted Service(s)	Note(s)
7	Managed Care of North America, Inc. (MCNA) Dental Plans	7/1/2009-6/30/2011	Dental Administration Services	
8	PerformRX	7/1/2008-6/30/2011	Pharmacy Benefit Management (PBM) Services	
9	SironaHealth, Inc. (IntelliCare, Inc.)	7/1/2008-6/30/2011	Nurse Advice Line Services	In response to the survey, Passport provided a list of vendors and subcontractors that indicated SironaHealth, Inc. was a Subcontractor between July 1, 2008 and June 30, 2011. However, Passport later provided a separate Vendor Payments file that indicates SironaHealth, Inc. was a subcontractor between July 1, 2008 and June 30, 2009; was **not** a subcontractor between July 1, 2009 and June 30, 2010; and, was again a subcontractor for the period between July 1, 2010 and June 30, 2011. We did not receive additional documentation that would allow us to confirm that SironaHealth, Inc was a subcontractor during the period between July 1, 2009 and June 30, 2010.
10	University Physician Associates (UPA or University Physician Group)	7/1/2008-6/30/2011	Credentialing Services	

Subcontracting Requirements – Contract between the Department and Passport

The contract between the Department and Passport includes specific requirements for the Department, the health plan, and any entity subcontracted to provide services under the health plan. Moreover, these contract terms also outline certain procedures that are required by both the Department and the health plan during the subcontracting process. Specific contract terms governing this process are as follows.

1. Section 1.3 (Contractor Function), Subsection 1.3.3 (Delegation of Authority), Part B states:

   Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

2. Section 1.7 (Subcontracts), Subsection 1.7.2 (Requirements) states:

The Contractor may, with the approval of the Department, enter into Subcontracts for the performance of its administrative functions or the provision of various Covered Services to Members. All Subcontractors must be eligible for participation in the Medicaid program as applicable. The Contractor shall submit for review to the Department each subcontract or contract prior to signing. The Department may approve, approve with modification, or deny subcontracts under this contract with cause if the subcontract does not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a subcontract, the Department may consider such factors as it deems appropriate to protect the State and Members, including but not limited to, the proposed subcontractor's past performance. Each Subcontract, and any amendment to an approved Subcontract, shall be in writing, and in form and content approved by the Department. In the event Contractor has not reached an agreement with Subcontractor within the applicable time frame, Contractor shall notify the Department and keep the Department informed of the status of the negotiations until the applicable contract is finalized. In the event the Department has not approved the subcontract prior to the scheduled effective date, Contractor agrees to execute said subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontract within ten (10) days following termination. (*emphasis added*)

The Department's subcontract review shall assure that all Subcontracts:

- Identify the population covered by the Subcontract;
- Specify the amount, duration and scope of services to be provided by the Subcontractor;
- Specify procedures and criteria for extension, renegotiation and termination;
- Specify that Subcontractors use only Medicaid providers in accordance with this Contract;
- Make full disclosure of the method and amount of compensation or other consideration to be received from the Contractor;
- Provide for monitoring by the Contractor of the quality of services rendered to Members, in accordance with the terms of this Contract;
- Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;

- Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;
- Contain an explicit provision that the Department is the intended third-party beneficiary of the Subcontract and, as such, the Department is entitled to all remedies entitled to third-party beneficiaries under law;
- Specify that Subcontractor agrees to submit Encounter Records in the format specified by the Department so that the Contractor can meet the Department's specifications required by this Contract;
- Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including without limitation, the obligation to comply with all applicable federal and Commonwealth law and regulations, including but not limited to, KRS 205.8451-8483, all rules, policies and procedures of the Department, and all standards governing the provision of Covered Services and information to Members, all QAPI requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of the Department, the Office of the Inspector General, the Attorney General and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations, all indemnification and insurance requirements, and all obligations upon termination;
- Provide for Contractor to monitor the Subcontractor's performance on an ongoing basis, including those with accreditation: the frequency and method of reporting to the Contractor; the process by which the Contractor evaluates the subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually.
- A subcontractor with NCQA accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.
- Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.
- The remedies up to, and including, revocation of the subcontract available to the Contractor if the subcontractor does not fulfill its obligations.
- Contain provisions that suspected fraud and abuse be reported to the contractor.

3. Section 1.7 (Subcontracts), Subsection 1.7.3 (Disclosure of Subcontractor) states:

> The Contractor shall inform the Department of any Subcontractor which engages another Subcontractor in any transaction or series of transactions, in performance of any term of this Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense.

Subcontracting Requirements – Compliance with the Contract

Myers and Stauffer's analyses were designed to determine PHP's compliance with the terms of its contract with the Department. These analyses required that we request documentation and information from the plan. As such, we requested that PHP provide documentation to confirm that it requested and received the Department's review and approval of all subcontractors and subcontractor contract amendments. We received documentation to confirm that PHP requested and received the Department's formal written approval of the UPA credentialing subcontract. We also received electronic mail (e-mail) correspondence between PHP and the Department confirming the Department's approval of the MCNA subcontract. It is our understanding that a formal written memorandum or (signed) letter, similar to that which we received for the UPA credentialing subcontract approval, would be required for the MCNA subcontract. However, we did not receive evidence that formal written approval of this subcontract was received by PHP.

Subcontractor Selection Process – Passport's Selection Methodology and Conflict of Interest / Related Party Policies and Procedures

Myers and Stauffer's analyses were designed to identify PHP's subcontractor selection criteria; selection methodology; and policies and procedures to identify, mitigate, and report conflicts of interest or related party interests. Despite multiple requests, we have not received documentation to indicate that PHP has formalized subcontractor selection criteria, methodology, or conflict of interest/related party policies and procedures for the period between July 1, 2008 and June 30, 2011.

During the course of our interviews with the health plan staff and management we attempted to determine whether defined criteria was formally in place to select subcontractors, and if so, what was the criteria. We were unable to gather sufficient information from the interviews to determine whether subcontractor selection criteria exist within the health plan. Furthermore, we were unable to confirm that policies and procedures exist to identify, mitigate, and report conflicts of interest or related parties.

In response to the Myers and Stauffer survey question, "Does health plan subcontract with or use as a vendor any subsidiaries or related corporate entities", the health plan indicated "No". Based on the apparent lack of policies and procedures that would

identify these entities, we are unable to determine how PHP concluded that it does not subcontract with or use as a vendor any subsidiaries or related corporate entities. Based on the research we performed for this engagement, and the information submitted by the health plan, it appears that the Passport Health Plan has had extensive relationships with related entities since PHP was formed.

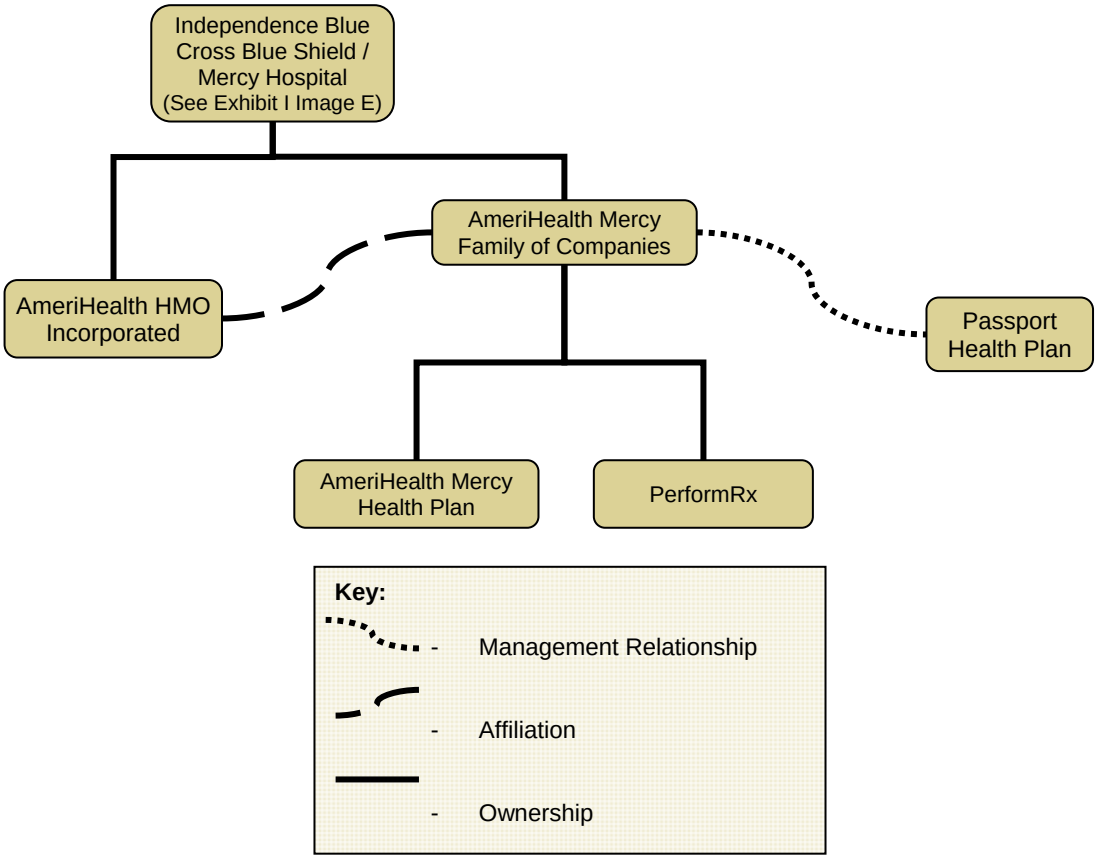
Subcontractor Selection Process – Conflict of Interest / Related Party Assessment

A) Myers and Stauffer's analyses were designed to identify potential subcontractor conflicts of interest and/or related parties. During our interview and analysis processes, we identified numerous related parties within the PHP subcontractor listing. Because of relevance to the PHP evaluation, not all organizations identified in the related party evaluation are included in the table below. Furthermore, other related parties beyond those identified during our evaluation may exist. PHP stated that they informed DMS of each of the related party subcontractor relationships shown below.

Table 2C-2: Apparent Relationships Between Passport and Subcontractors

Row Identifier	Subcontractor Name	Image (See Exhibit I)	Apparent Relationship
1	AmeriHealth HMO Incorporated	A	Affiliated with AmeriHealth Mercy Health Family of Companies.
2	AmeriHealth Mercy Health Plan	B, C, D	Part of the AmeriHealth Mercy Family of Companies. AmeriHealth Mercy Family of Companies holds a Management Services Agreement with Passport Health Plan.
3	PerformRX	B, C, D	Part of the AmeriHealth Mercy Family of Companies.

Figure 2C-1: Diagram of Apparent Passport and Subcontractor Relationships



B) After evaluating the relationships, we also analyzed the documentation received from the health plan to determine compliance with the Kentucky Administrative Regulations (KAR) and Code of Federal Regulations (CFR) pertaining to disclosure of relationships with affiliated parties. Certain state and federal regulations within the KAR and CFR describe a health plan's requirements in this area:

1. 907 KAR, Section 5 (Partnership Requirements. Each partnership shall):

   (b) File a financial disclosure report, as required by the Health Care Financing Administration and pursuant to 42 CFR Part 455, with the department within 120 days of the end of the contract year and within forty-five (45) days of entering into, renewing, or terminating any transaction with an affiliated party;

2. 42 CFR Part 455 Subpart B (Disclosure of Information by Providers and Fiscal Agents):

   § 455.104 Disclosure by providers and fiscal agents: Information on ownership and control.

   (a) Information that must be disclosed.

   The Medicaid agency must require each disclosing entity to disclose the following information in accordance with paragraph (b) of this section:

   (1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more;
   (2) Whether any of the persons named, in compliance with paragraph (a)(1) of this section, is related to another as spouse, parent, child, or sibling.
   (3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person.

   The disclosing entity must —

   (i) Keep copies of all these requests and the responses to them;
   (ii) Make them available to the Secretary or the Medicaid agency upon request; and
   (iii) Advise the Medicaid agency when there is no response to a request.

   (b) Time and manner of disclosure.

   (1) Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified in paragraph (a) of this section to the State survey agency at the time it is surveyed. The survey agency must promptly furnish the information to the Secretary and the Medicaid agency.
   (2) Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified in paragraph (a) of this section to the Secretary within the prior 12-

month period, must submit the information to the Medicaid agency before entering into a contract or agreement to participate in the program. The Medicaid agency must promptly furnish the information to the Secretary.
(3) Updated information must be furnished to the Secretary or the State survey or Medicaid agency at intervals between recertification or contract renewals, within 35 days of a written request.

(c) Provider agreements and fiscal agent contracts. A Medicaid agency shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information as required by this section.

(d) Denial of Federal financial participation (FFP). FFP is not available in payments made to a provider or fiscal agent that fails to disclose ownership or control information as required by this section.

Documentation we received appears to show that disclosures were submitted to the Department only during the period between July 1, 2009 and June 30, 2010 and only for two subcontractors, MCNA and PerformRx.

We submitted several inquiries related to the above issues to PHP and received the following responses on February 13, 2012.

Myers and Stauffer: Please describe PHP's methodology for ensuring that payments to subcontractors were commensurate with the value that PHP received from the subcontract.

PHP Response: We were unable to find written documentation of the methodology for ensuring that payments to subcontractors were commensurate with the value that PHP received from the subcontract. Our understanding is that, during the audit period, subcontractor oversight was handled by UHC management and the Board Oversight Committee. UHC management monitored the services provided by subcontractors including onsite visits to subcontractors and assessed whether UHC received appropriate value for the services provided. In addition, the Board Oversight Committee provided oversight of the services provided by AMHP and contracted with AMHP to provide oversight of the services provided by other subcontractors (e.g., Doral, MCNA, Block Vision, etc.). These oversight activities included an assessment of whether UHC received appropriate value for the services provided.

Our current process is to use our Board Oversight Committee, Finance Committee and a management subcontractor strategy team to assess whether payments to subcontractors are commensurate with the value UHC received from the subcontract. For example, one action taken by each of these groups is to perform a comparison of the services and price provided on the market for certain contracted services with the range of services and price paid by UHC. We have also developed a competitive RFP strategy and will be systematically reviewing all of our subcontractor relationships over the next two years.

Myers and Stauffer: Please describe the process that was used to ensure that conflicts of interest did not occur between PHP/AMHP staff and related party subcontractors.

PHP Response: We were unable to find written documentation of the process used to monitor conflicts of interest other than having a Conflict of Interest policy in place and having Board members and associates sign Conflict of Interest statements. Our understanding is that, during the audit period, the Board Executive Committee monitored whether conflicts of interest occurred between UHC and AMHP. We have implemented substantive improvements in our compliance and ethics program. The management of conflicts of interest is the responsibility of the Board and Senior Management. At a minimum, the Board reads a conflict of interest statement before each meeting and includes a conflict of interest discussion as part of its Board orientation program.

C) During the course of our evaluation of subcontractor relationships, we also studied information from the Kentucky Secretary of State website in an effort to ensure that the subcontractors included in the documentation provided by PHP are or were appropriately registered in the Commonwealth of Kentucky as business entities. The table below describes the outcome of this evaluation:

Table 2C-3: Passport Subcontractor Status with Kentucky Secretary of State

Row	Subcontractor Name	Service Period	Subcontracted Service(s)	Image (See Exhibit I)	Secretary of State Status
1	AmeriHealth HMO Incorporated	7/1/2008-6/30/2011	Family Planning Services	F	Active – Effective 11/17/2009
2	AmeriHealth Mercy Health Plan	7/1/2008-6/30/2011	Health Plan Administration / Management	G	Active – Effective 5/26/2011
3	Block Vision, Inc.	7/1/2008-6/30/2011	Vision Administration Services	H	Active – Effective 10/24/1997
4	DentaQuest (Formerly Doral)	7/1/2008-6/30/2009	Dental Administration	I	Active – Effective 5/29/2003

Table 2C-3: Passport Subcontractor Status with Kentucky Secretary of State

Row	Subcontractor Name	Service Period	Subcontracted Service(s)	Image (See Exhibit I)	Secretary of State Status
			Services		
5	Healthcare Options Incorporated	7/1/2009-6/30/2010	Unknown	J	No matching company identified
6	ikaSystems Corporation	7/1/2010-6/30/2011	Unknown	K	Active – Effective 3/1/2011
7	Managed Care of North America, Inc. (MCNA) Dental Plans	7/1/2009-6/30/2011	Dental Administration Services	L	Active – Effective 12/30/2008
8	PerformRX	7/1/2008-6/30/2011	Pharmacy Benefit Management (PBM) Services	M	Active – Effective 12/11/2009
9	SironaHealth, Inc. (IntelliCare, Inc.)	7/1/2008-6/30/2011	Nurse Advice Line Services	N, O	Active – Effective 2/8/2011
10	University Physician Associates (UPA or University Physician Group)	7/1/2008-6/30/2011	Credentialing Services	P	Active – Effective 10/1/2002

Based on this portion of the evaluation, several subcontractors were not properly registered with the Secretary of State at some point during the contract periods. In response to our inquiry, PHP provided the following response regarding these subcontractors on February 13, 2012.

> Sironahealth was not registered between 3/1/2009 and 2/8/2011. AmeriHealth HMO, Inc. was not registered between 9/19/1997 and 11/17/2009. MCNA of Kentucky, LLC was registered as Managed Care of North America of Kentucky, LLC from 12/08 and is registered as MCNA Dental as of 10/11 based on the recommendation of the IPRO audit. Passport now reviews for Active/Good Standing on the Secretary of State website as part of our Pre-Delegate Assessment as well as a semi-annual review for all subcontractors.

AMHP stated that AMHP was registered with the Secretary of State from November 4, 1997 to November 1, 2002 and is active since November 17, 2009. However, when we inquired, the Secretary of State did not confirm these statements. The information provided by the Secretary of State supported our findings.

√ Observations, Findings or Recommendations Related to the Selection of Subcontractors

1) Based upon apparent inconsistencies in subcontractor reporting for purposes of these analyses, it appears that PHP might not have consistently applied the contract definition of the term "Subcontractor" throughout its business processes during the examination period. Documentation and information received from the health plan suggests that the terms "vendor" and "subcontractor" have, at times, been used interchangeably and thus contract compliance with terms applicable to subcontractors, and tracking and reporting on subcontractors, appears to be an issue for the health plan as a result of this apparent inconsistency. It is important that PHP develop a clear understanding on which of the contracts constitute "subcontractor" services per terms of the contract between DMS and UHC. The likelihood of compliance becomes less likely as more entities are involved in the PHP model, and the more time that elapses without such agreement. PHP has indicated that they are working with DMS to obtain a clear understanding of the definition of a subcontractor.

2) PHP did not receive the Department's formal written approval for some subcontractor contract executions and/or amendments during the period between July 1, 2008 and June 30, 2011.

3) We have not received documentation to indicate that PHP has formalized subcontractor selection criteria, methodology, or conflict of interest/related party policies and procedures. Furthermore, we were unable to confirm that policies and procedures exist to identify, mitigate, and report conflicts of interest or related parties. The PHP business model, which is an integrated provider-sponsored delivery system, comes with increased risk of conflicts of interest by the very definition of the model. This increased risk should not imply an indictment of the model. However, it does require added responsibilities of oversight, detection, monitoring, and reporting in a highly transparent environment, the success of which depends heavily on the strength of entity-wide policies and procedures.

4) We identified several subcontractor relationships that might require conflict of interest or related party mitigation and/or evaluation by the Department to determine the appropriate next steps.

5) Analysis of documentation indicates that certain related party disclosures were submitted to the Department only during the period between July 1, 2009 and June 30, 2010 and only for two subcontractors, MCNA and PerformRx.

6) We identified subcontractors who were not properly registered with the Secretary of State at some point during the contract period(s). Although AMHP stated that it was properly registered for a period of time, the Secretary of State did not confirm this statement and agreed with our findings. PHP should consult with DMS to determine the appropriate next steps, if any.

Objective 2D: Methodology of Payments to Subcontractors

The objectives of this analysis include the following component:

- Examine the methodology of payments to subcontractors and providers.

Myers and Stauffer solicited information regarding the payment methodology used by Passport to make payments to each subcontractor and to providers. Below, we have prepared a summary of each primary provider type and each contractor, and the primary payment methodologies used by Passport Health Plan. Please note that we did not receive all of the contracts and information necessary to complete this information.

Subcontractor Payment Methodologies
In the tables below, we present information regarding the payment methodologies used for known subcontractors, and for which we received documentation from the health plan. Please also refer to the detailed information by subcontractor included in the sections below.

Subcontractors	Reimbursement Methodology					
	PMPM	Cost + Fixed Fee + PMPM	% of Revenue (AMHP Incentive Pool)	Hourly	Unknown	Total
Contracted Health Plan Service Providers	4	1	1	1	1	8
	50%	12.5%	12.5%	12.5%	12.5%	100%

Observations related to subcontractor payment methodologies:

- One of eight subcontractors, PerformRx, received some form of bonus or incentive payment.

- One of eight subcontractors appears to be generously reimbursed. Based on our understanding of the contract terms, PerformRx receives reimbursement for actual provider payments, plus a PMPM amount for administration, fixed fees for incentive payments and other services provided and they retain 60 percent of the

Medicaid rebates received. Because PerformRx is a related party to AMHP, and because AMHP held key management positions within the health plan, there is a potential increased risk that AMHP management personnel may have been involved in contract negotiations with PerformRx.

We requested that Passport provide an explanation on the contract costs for PerformRx to illustrate that the payments Passport makes for PerformRx services are based on the value provided by PerformRx, and that these payments are comparable with other PBM vendors. Passport provided the following response:

> The contract costs paid to PerformRx include administration fees for claims payment, drug utilization review, network management, data reporting, formulary management and clinical authorizations. In addition, incentive payments are made to the PBM upon successful completion of mutually agreed upon measures. These measures focus on cost containment, quality and clinical outcomes, The PBM is also paid a percentage of manufacturer rebates. Since the previous management of UHC negotiated the terms of the PBM contract, the Plan consulted with Advance Pharmacy Concepts to conduct an evaluation of the PBM contract compared to industry standards. Advance Pharmacy Concepts (APC) is a nationally respected, independent firm with expertise in pharmacy benefit programs and services. Findings from their analysis reveal reimbursement for certain contract elements such as payment for rebates and incentives are outside of industry standards. To ensure we are receiving the best value for PBM services, the Plan intends to issue an RFP in 2012.

- PHP subcontractors reimbursed via a per member per month capitation arrangement present enhanced risks related to appropriate recording of administrative and medical expenses.

- The AmeriHealth HMO family planning contract, while specifying that the HMO will be reimbursed utilizing a per member per month capitation arrangement, also includes a provision for a guaranteed minimum fee and number of member months per year. Because AmeriHealth HMO is a related party to AMHP, and because AMHP held key management positions within the health plan, there is a potential increased risk that AMHP management personnel may have been involved in contract negotiations with AmeriHealth HMO. We requested that Passport provide us with their justification for the reimbursement paid to AmeriHealth HMO. PHP provided us with the following response:

  > AmeriHealth HMO is not a “full risk” subcontractor. They function as a TPA to process and pay Passport’s family planning claims. Passport

reimburses AmeriHealth HMO for the full cost of the claims they process and then Passport pays AmeriHealth HMO a small administrative fee. This fee is $0.113 pmpm or approximately $19,000 per month.

- AMHP is reimbursed based on a percentage of PHP revenue. Note this methodology changed with the transition occurring effective July 1, 2011. Because AMHP held key management positions within the health plan, there is a potential increased risk that AMHP management personnel may have been involved in contract negotiations to determine the percentage of PHP revenue to be retained by AMHP for administration.

Provider Payment Methodologies

In the tables below, we present information regarding the payment methodologies used for various provider categories, and for which we received documentation from the health plan. Please also refer to the detailed information by provider category included in the sections below.

Health Care Providers	Reimbursement Methodology				
	Fee for Service (FFS)	Capitation	Encounter Rate (RHC) Plus Case Management	Urgent Care per Visit Fee	Total
Health Care Provider Categories	15	1	1	1	18
	83.3%	5.5%	5.5%	5.5%	100%

Observations related to health care provider category payment methodologies:

- Hospital Services:
  - Radiology reimbursed 200 percent of PHP fee schedule (i.e., twice amount received by independent radiology centers)
  - Therapies, implants, chemotherapy services reimbursed as percent of charges
  - Inpatient hospital reimbursement based on per diem
  - Outpatient hospital reimbursement based on fee schedule

- Primary Care Physician:
  - PMPM reimbursement based on age and enrollment category
  - Services not listed in PCP agreement paid separately as FFS, which includes newborn delivery
  - Services provided to presumptive eligibility members reimbursed using fee schedule

- Incentive payments for timely submission of encounters
- Other capitation related bonus payments available

- Vision Care:

  - Reimbursement available for contact lenses (youth only)

Summary of Subcontractor Reimbursement

Below is a table outlining each subcontractors general terms of reimbursement. General terms were obtained through a review of each contract. Contracts for Dental and Vision services indicated the specific procedures covered. Reimbursement amounts and services rendered may have been adjusted during various periods of the contract term.

Subcontractor Name	Services Rendered	Reimbursement Methodology	Rate Details & Other Notes
Block	Vision Services	Capitation	$3.48 PMPM under 21; $1.72 PMPM over 21; Bonus payments were available in prior contract period; Other rates applicable depending on period covered.
MCNA	Dental Services	Capitation	$15.53 PMPM ; Other rates applicable depending on period covered; Subcontractor will reimburse providers at 105% of Medicaid Fee Schedule.
Doral	Dental Services	Capitation	PMPM – Vendor was replaced by MCNA
University Physician Associates	Network Services	Hourly	$75.00 per hour
University Physician Associates	Credentialing	None	No-cost contract
PerformRx	Pharmacy Benefit Manager	Cost + Fixed Fee + PMPM	Actual Provider Payments plus PMPM for administrative expenses; Extensive fixed fees paid for Incentives and other services rendered. PBM keeps 60% of Medicaid rebate.
IntelliCare	Nurse Advice Line		Not indicated in modified contract – Original contract not available.
AmeriHealth	Management Services	Percent of Revenue	Start-up costs plus a percentage of total revenue (a portion of which is used to fund the incentive pool).
AmeriHealth HMO	Family Planning Services	Capitation	Contract provision for minimum number of member months/ fee per year.

Summary of Provider Contracts

Below is a table listing contracts reviewed and the general terms of reimbursement. Generally, provider contracts appear to be standard agreements. Specific pricing and other program specific requirements were attached as an appendix. Each contract requires the provider to accept payment from the HMO as a full settlement of the charges except for copayments, deductibles, or other coordination of benefits. Each contract permits a provider to bill the member for non-covered services if the member is aware that they will be financially responsible for the service and agrees to this arrangement in writing. Each contract indicates that it is subject to oversight by the Department.

Provider Type	Payment Methodology	Detailed Rate Information	Prior Authorization Required
Ambulance	FFS	Lesser of U&C or Fee Schedule.	Yes
Ambulatory Surgical Centers	FFS	Per Case using ASC Grouper - Case rates range from 381.69 - 1178.29; Ungrouped codes are reimbursed at 55% of charges. Surgical Implants are paid at cost of implant exceeding $100 + 10%.	Yes
Dialysis	FFS	100% of current Medicare Fee Schedule.	Yes
Audiology	FFS	Fee schedule or 105% of Medicaid if not listed.	Yes, if over $500
DME	FFS	88% of Medicare Fee Schedule.	Yes
Department of Health	FFS	Fee Schedule.	Not indicated as required
Home Health	FFS	Lesser of U&C or Fee Schedule.	yes

Provider Type	Payment Methodology	Detailed Rate Information	Prior Authorization Required
Home Infusion DME	FFS	Per Diem/Per Service; Secondary and additional therapies occurring on same day are discounted. Rx is reimbursed at AWP - 15%.	Not indicated as required
Hospice Services	FFS	Lesser of U&C or current Medicare Fee Schedule.	Not indicated as required
Hospital Services	FFS	Radiology - 200% of Passport Fee Schedule; Laboratory - 100% of Passport Fee Schedule; Therapies & implants - 55% of charges; Chemotherapy - 75% of charges; Other outpatient services - Fee schedule; Inpatient - Per Diem.	Not indicated as required
Independent Laboratory	FFS	85% of Medicare Fee Schedule.	Not indicated as required
Primary Care Physician	Capitation	PMPM based on Age and Enrollment category. Services not listed in the PCP agreement can be billed separately as FFS (i.e. newborn delivery); Bonus of $1 per member for timely submission of encounters; Presumptive Eligible members are Fee Schedule reimbursed; X-over claims - FFS; Foster Care - FFS; Other capitation Bonuses available.	Not indicated as required
Radiology	FFS	Fee Schedule.	Not indicated as required
Rural Health Clinics	FFS – Per Visit Rate	All inclusive encounter rate using Prospective Payment System; Also includes $8 PMPM case mgt fee; X-over – FFS.	Not indicated as required
Specialty Care	FFS	Fee Schedule.	Not indicated as required
Vision Care	FFS	Fee Schedule; Includes exam, glasses (and contacts for youth).	Not indicated as required

Provider Type	Payment Methodology	Detailed Rate Information	Prior Authorization Required
Dental Care	FFS	105% of Medicaid Fee Schedule; Fixed fee for orthodontic procedures.	Only for orthodontic procedures
Urgent Care Provider	FFS – Per Visit Rate	Per Visit Flat Rate of $101.11; Referrals required for visits between 8-4 M-F.	Not indicated as required

We noted that hospital based radiology services are reimbursed at 200 percent of the PHP fee schedule amount and that the amount paid to hospital based providers is twice the amount paid to independent radiology centers. When questioned about this methodology, PHP provided the following response:

> Per PHP hospital agreements, the rate for hospital based radiology is 200% of the technical component of the Passport Medicaid fee schedule. The technical component in additional to the professional component equal a global rate. In the PHP contract structure, use the technical component as the base rate in the calculation of a global radiology payment. For example if the global rate is $100 and the technical rate is $60, based on our contract structure the reimbursement would be set at $120, not $200. Original fee schedules and calculation methodologies were established at plan startup using Milliman to review the state data book. Fee schedules are evaluated at least annually to ensure we are not paying less than Medicaid. Because Passport is at risk for the members we serve, we do not mirror DMS reimbursement methodologies, but strive to ensure we are providing fair compensation to our providers.

√ Observations, Findings or Recommendations Related to the Methodology of Payments to Subcontractors

1) Based upon our review of the provider contracts effective between July 1, 2008 and June 30, 2011, these contracts appear to all contain standard language within the body of the contract, with the reimbursement terms or other terms specific to the provider in the appendices of the contract. With the exception of PCP, all appear to be FFS based contracts with a reference to a fee schedule. The PCP contract appears to reimburse the provider at a PMPM rate for specific services identified in one of the appendices. The PCP provider is further reimbursed on a FFS basis for specific procedures not covered under the PMPM rate. This list of procedures is clearly identified in Appendix C. Selected eligibility groups are also reimbursed on a FFS basis and as such, the PCP receives no capitation payment for these members. Finally, the PCP provider is eligible for certain incentive payments based on utilization and other practice characteristics. The PCP provider is provided a bi-monthly incentive payment to submit encounters detailing the PMPM services provided.

2) We identified within the Pharmacy Benefit Manager (PBM) contract a sub-contractor, Argus, to the PBM. This subcontract relationship, which appears to have been enacted in 2004 and modified in 2010, is to provide all family planning pharmaceutical products. Department policies expressly prohibit this type of subcontract unless expressly approved. This extensive contractor and subcontractor relationship required disclosure and approval by the Department.

3) The reimbursement provided to PerformRx is significant. Please note that we have not performed analysis to determine whether the services provided by PerformRx justify the rates received. If they have demonstrated return on investment through formulary management, rates for multiple source products, drug interchange activities, rebate agreements, and patient compliance programs that substantially reduce costs, then the reimbursement rates may be justified. With the relationship between AMHP and PerformRx being a consideration, and the likelihood that AMHP personnel who served in key management positions within the health plan may have participated in the contract negotiations with PerformRx, increased risk to both PHP and the Department exists. PHP has indicated that the negotiated contracts were reviewed by an outside consultant in order to reduce the risk associated with the related parties and Passport plans to reprocure these services in 2012.

4) The PBM contractor receives a pharmaceutical administrative fee of $0.513 per member per month (PMPM). This fee is intended to reimburse the subcontractor for the cost of submitting and collecting rebates associated with the pharmaceutical program. However, the PBM is only required to submit to

Passport 40 percent of the rebates collected, for Medicaid and CHIP members, despite receiving an administrative fee for the costs of administering this program. The PBM was required to submit to Passport 90 percent of the collected rebate for Passport Advantage members.

5) Passport appeared to require in its subcontracts a "Kentucky Medicaid Program - Disclosure of Ownership and Control Interest Statement" and indicated that questions 1-12 were required to be answered. For some subcontractors, this document may not have been completed.

6) Bonus and incentive payments are included in both subcontractor/vendor contracts and health care provider contracts. Such payments can be effective at driving quality and member and provider satisfaction. However, if not carefully evaluated and monitored, there may be limited value realized for the additional reimbursement.

7) There is a risk that PHP reimbursement for family planning services could be excessive. The AmeriHealth HMO family planning contract, paid utilizing a capitation reimbursement methodology, also includes a guaranteed minimum number of services and a minimum fee paid annually.

OBJECTIVE 2E: VALIDITY OF INCENTIVES

The objectives of this analysis included following components:

Assess the validity of incentives awarded to Passport subcontractors and their employees and provider network including, but not limited to, the following:

a. Methodology for determining the incentive goals/outcomes

b. Monitoring activities in place to determine that goals were appropriately met

c. Methodology for determining incentives, if any

d. The value of the benefit received compared to the amount of the incentive offered

e. Comparison of incentive payments among providers

f. Reasonableness in determining the amount of the incentive

General Approach

Myers and Stauffer developed a data and documentation request that was sent to Passport Health Plan. This request solicited information regarding any incentives that were paid to Passport subcontractors or eligible health care providers. The work plan included an assessment of the methodologies that are used to determine payments, with a goal of verifying that the receiving entity was eligible to receive the payment. In addition to assessing the eligibility of payments, we attempted to analyze the value and benefits of the incentive payments, the distribution among receiving entities, the reasonableness of the payment amounts, and the process used to report such payments to the Department. The analysis of incentive payments included an assessment of the contract requirements between DMS and UHC.

Incentive Payments

As part of the evaluation of the prevalence and permissibility of incentive payments, we analyzed the requirements of the contract between DMS and UHC, the Kentucky Administrative Regulations, and the Code of Federal Regulations. Below are the findings from each of the guiding parameters.

Requirements of the Contract between DMS and UHC	
Citation	**Requirement**
1.7.5 Physician Compensation Plans	Any compensation arrangement between the Contractor and a physician, or physician group as that term is defined in 42 C.F.R. § 417.479(c), or between the Contractor and any other Primary Care Providers within the meaning of this Contract, or between the Contractor and any other Subcontractor or entity that may directly or indirectly have the effect of reducing or limiting services provided to Members must be submitted to the Department for approval prior to its implementation. Approval is preconditioned on compliance with all applicable federal and Commonwealth laws and regulations. The Contractor must provide information about any Physician Incentive Plan to any Member upon request.

Requirements of the Kentucky Administrative Regulations	
Citation	**Requirement**
907 KAR 1:705 Section 6. Partnership Payments	(4) The department shall provide financial incentive payments to partnerships upon achievement of health care outcomes as specified in Section 10(1)(a)2 of this administrative regulation. These outcomes shall be selected in collaboration with each partnership and based upon the demographic characteristics and health status of members in the partnership region. The incentive payment shall be an amount up to one (1) percent of the capitation payment and made annually by the department.
907 KAR 1:705 Section 10. Quality Improvement	2. Health care outcomes, including members' risk factors, functional status, morbidity and mortality, readmission to health care facilities, satisfaction with care, and effect of education programs. The health care outcomes shall be based on the performance indicators and standards set forth in specified portions of the Health Plan Employer and Data Information Set (HEDIS). To achieve these health outcomes, the department shall develop a list of benchmarks for which financial incentive payments may be received by the partnership and a list of benchmarks that partnerships shall be required to meet or show progress toward meeting. The lists of incentive benchmarks shall be provided by the department in collaboration with each partnership on an annual basis.

Requirements of the Code of Federal Regulations Title 42	
Citation	**Requirement**
§ 438.6 Contract requirements. C. (iv)	Incentive arrangement means any payment mechanism under which a contractor may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.
§ 438.6 Contract requirements. B. (iv)	An explanation of any incentive arrangements, or stop-loss, reinsurance, or any other risk-sharing methodologies under the contract.
§ 438.6 Contract requirements. 5. (iii)	Contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered to be actuarially sound.
§ 438.6 Contract requirements. 5. (iv)	For all incentive arrangements, the contract must provide that the arrangement is— (A) For a fixed period of time; (B) Not to be renewed automatically; (C) Made available to both public and private contractors; (D) Not conditioned on intergovernmental transfer agreements; and (E) Necessary for the specified activities and targets.
§ 438.6 Contract requirements. 4. (h)	Physician incentive plans. (1) MCO, PIHP, and PAHP contracts must provide for compliance with the requirements set forth in §§ 422.208 and 422.210 of this chapter. (2) In applying the provisions of §422.208 and 422.210 of this chapter, references to ''M+C organization'', ''CMS'', and ''Medicare beneficiaries'' must be read as references to ''MCO, PIHP, or PAHP'', ''State agency'' and ''Medicaid recipients'', respectively.
§ 438.700 Basis for imposition of sanctions. b. (6)	(b) A State determines whether an MCO acts or fails to act as follows: … (6) Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in §§ 422.208 and 422.210 of this chapter.
§ 438.704 Amounts of civil money penalties. b. (iii)	Paragraph (b)(6) (Failure to comply with physician incentive plan requirements).

Requests for Incentive Payment Data

We requested from Passport Health Plan a listing of non-claim-specific incentive payments made during the engagement window (i.e., July 1, 2008 through June 30, 2011). We asked that Passport include the date of payment, payee, payee address, method (of payment such as check, cash, wire transfer, etc.), check number, amount, and a detail description of the incentive and basis for the payment. Additionally, we asked for detail supporting the incentive payment calculations including formulas, contractual provisions, guidelines, state plan amendments or other regulations/statute authorizing the payment.

For purposes of the comparison survey (please also see Objective 1B) an additional request for information related to incentives was sent to PHP on September 15, 2011, which requested information specific to SFY 2011. The comparison survey included the following questions:

- Does the contract with the Medicaid agency include limitations, restrictions, or requirements for health plan issued/awarded incentive payments?
- Does the health plan make incentive payments?
- How are incentives computed?
- What types of entities are eligible for and/or received incentive payments?
- How are payments made?
- Who within the health plan oversees and/or monitors incentive payments?
- What is the Medicaid agency's role (if any) to authorize incentive payments?
- What are the responsibilities or obligations of the receiving entity?

Types of Incentive Payments Made by PHP

During the engagement window, PHP made incentive payments in two contract categories, including incentive payments made to health care providers and incentive payments made to subcontractors and/or vendors.

Health Care Provider Related Incentive Payments

In response to the request for data and documentation, the health plan submitted incentive payment data for four provider recognition programs (PRPs). The programs include the following categories: Primary Care Practitioner PRP, Specialist Care PRP for Member Satisfaction Measures, Specialist Care PRP for Pain Management Measures, and Specialist Care PRP for Postpartum Measures.

Primary Care Practitioner Provider Recognition Program

PHP presented a policy entitled "PR 89.0" to support the primary care related PRP payments. PR 89.0 appears to have been adopted January 24, 2007. Oversight of the primary care PRP is the responsibility of the PCP workgroup, which "consists of primary care physicians along with [PHP] staff…[that] meets quarterly and is responsible for program oversight and evaluation." The stated policy, purpose, and scope of PR 89.0 are presented in the following two paragraphs.

> *Passport Health Plan (PHP) adopted and implemented a Primary Care Practitioner (PCP) Provider Recognition Program (PRP) that rewards providers who demonstrate improvement and/or excellence in performance in the categories utilization, member satisfaction, access to care and health outcomes. The Plan's PRP is evaluated annually and subsequently adjusted in accordance with health plan needs and opportunities. The Partnership Council has granted authority of program oversight and evaluation to the Plan's PCP work group. The PRP is conducted in accordance with the procedures outlined in this policy.*
>
> *The PRP is designed to further deliver the Plan's mission of improving the health and quality of life for PHP members. The program design is composed of clinically sound measures relevant to the Plan's population. PHP recognizes national trends associated with PRP models and is committed to remain in tandem with those trends. These include sound methodology that is fair and equitable to all practitioners involved and considers national initiatives. The program development is achieved through collaboration between the Plan and representatives of the primary care network to select measures develop criteria and oversee implementation.*

Incentives paid through the physician recognition program totaled more than $14.4 million during the audit window. PHP personnel described the process for determining eligibility and computing payments for the PRP. The PRP operates on a rolling 12 months with annual calculations.

- Payments are made quarterly and are approximately 16 months in arrears.
- Incentives are set at a baseline of one percent to two percent of the PCP rates, which are paid on a sub-capitation basis.
- PRP includes 240-260 providers at the group level. Incentives are paid at the group level.
- All PCP's are eligible to participate with everyone calculated in the first quarter of the calendar year starting with the average screening rate of the plan.

- The provider reviews the medical records for reconsideration to support screenings not included in the encounter data (PHP sends a negative list).
- There are separate criteria for different screening types and the criteria are built on the NCQA and EPSDT standards.
- The reconsideration period lasts 30-60 days and is usually completed within the quarter. RN's are used to review the reconsideration data. PHP is still actively settling the 2010 reconsiderations.
- A move has been made to switch to more real-time data by utilizing more canned reports and customizable queries.

Specialist Care Provider Recognition Program

PHP presented a policy entitled "PR 112.0" to support the specialist care related PRP payments. PR 112.0 appears to have been adopted January 29, 2010. Based on this adoption date, it would appear that PHP may have made PRP payments despite the fact that a formal, approved policy had not been authorized by DMS.

Unlike the Primary Care Practitioner PRP which is guided by the PCP workgroup, the UHC Board of Directors "has ultimate authority of the [specialist care] program. The AVP of Provider Relations and VP of Operations are responsible for ongoing oversight of the program with day-to-day operations carried out by the Manager of Provider Services and the PRP representative."

The PR 112.0 document describes that the Specialist Care PRP was implemented in 2008. The stated policy, purpose, and scope of PR 112.0 are presented in the following two paragraphs.

> *Passport Health Plan implemented a Specialist Provider Recognition Program (PRP) that rewards specialist care practitioners for improvement and/or excellence in the categories of prenatal care, post partum care, member satisfaction, and access to care. The University Health Care Board of Directors oversees and approves incentive dollars to distribute among specialist providers. The Plan's Specialist PRP is evaluated annually and subsequently adjusted in accordance with Health Plans needs and opportunities.*
>
> *The Specialist PRP is designed to further the Plan's mission to improve the health and quality of life for our members. The program was designed to include clinical and service indicators, support UHC's goal of achieving recognition as one of the top five Medicaid health plans in the country, and to partner with specialty care practitioners to identify and target specific improvement goals and the incentives associated with these goals.*

During our interviews with PHP personnel, we noted the following additional information regarding the Specialist Care Program incentives:

Member Satisfaction

- This incentive program was based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient satisfaction with their doctor and is open to every specialist with encounters. It was open to all rural and urban providers.
- Survey data was collected through telephone calls to the members and kept in a database.
- The sample size was large and the purpose was to seek ways to be more efficient. There were 12-15 questions with a percent of positive responses recorded.
- These results were rolled up to the group level. A majority of the providers received a payment if they had an encounter during the review year.
- Payments during the engagement window totaled $2 million.
- There was no reconsideration process for this incentive program.

Pain Management

- The primary purpose of the pain management incentive program was to increase access to pain management specialists.
- To qualify the specialist must: 1) accept new members; 2) have an active contract; 3) prove the patient had not been seen for over a year. PHP claims data was used to determine whether the patient was a new patient or not.
- Payments totaling $300,000 over the engagement window were authorized by Executive VP and were made to approximately 10-12 physician groups.
- There was no reconsideration process for this incentive program.

Postpartum Incentive Program

- The Postpartum incentive program was designed to encourage providers to deliver postpartum care between 21 and 56 days post delivery. It was eligible to contracted urban and rural providers.
- The incentive was based upon improvement percentages. Per PHP personnel, there were a range of improvements with an annual assessment.
- There was a reconsideration period where the provider could submit additional documentation.
- Total payments during the engagement window were $400,000.
- Per PHP personnel, the postpartum program funds were suspended and likely would have been cut for 2012 because of financial performance and budget issues.

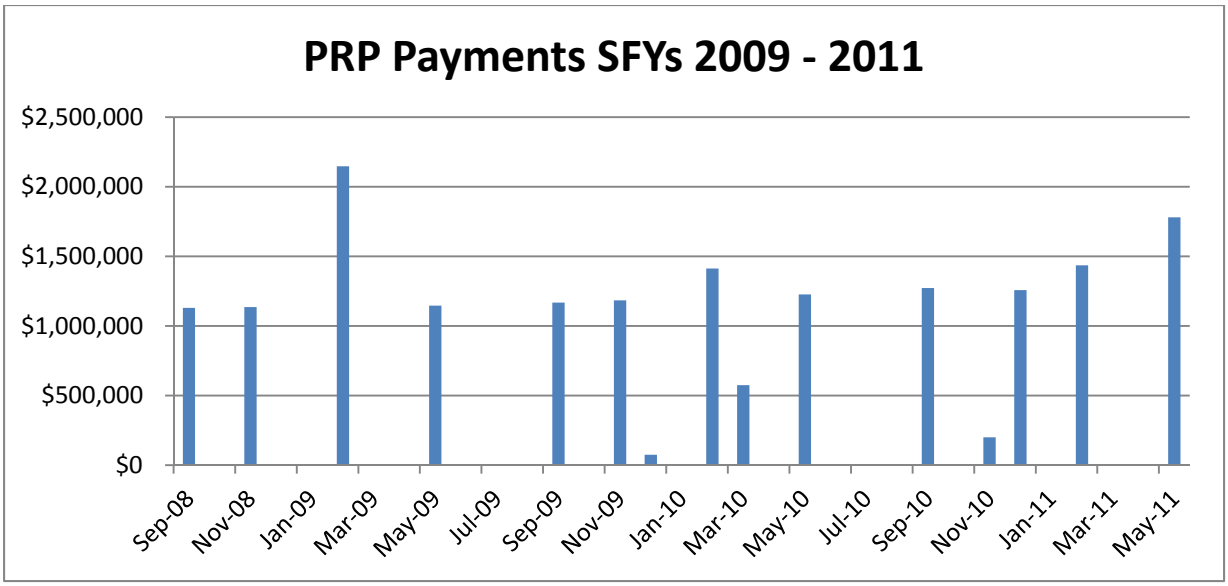
Provider Recognition Program Payments

Incentive payments for the aforementioned programs totaled approximately $17.5 million over the period covered by the examination. The table and charts below provide additional information regarding the month and year of payments, the PRP, and the total payments within the specified periods.

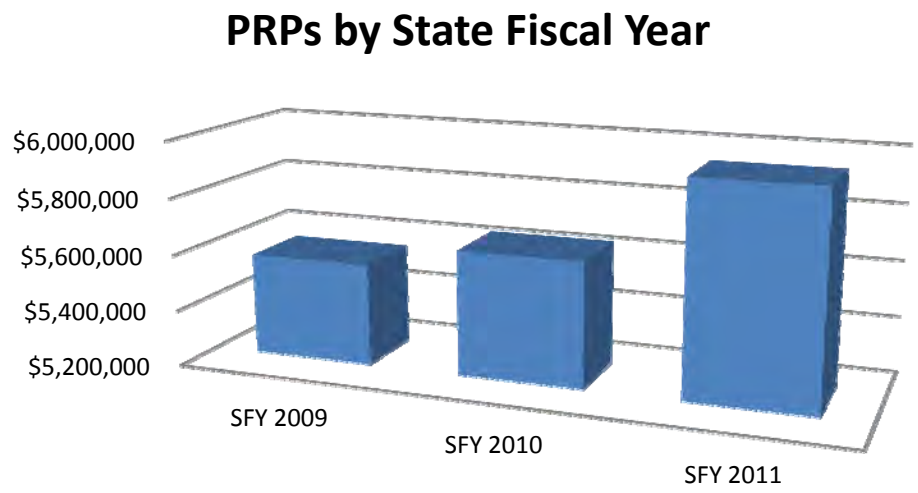
The Primary Care Practitioner PRP comprised 84.2 percent of the total incentives. The remaining 15.8 percent of PRP payments were shared among the three specialist care PRPs, with the majority of those payments based on the member satisfaction measure.

Provider Recognition Programs SFYs 2009 - 2011					
	Primary Care Practitioner PRP	Specialist Care PRP			Total
		Member Satisfaction	Pain Management	Postpartum Measure	
Sep-08	$1,130,455	$0	$0	$0	$1,130,455
Nov-08	$1,135,959	$0	$0	$0	$1,135,959
Feb-09	$1,147,652	$1,000,000	$0	$0	$2,147,652
May-09	$1,146,225	$0	$0	$0	$1,146,225
Sep-09	$1,167,879	$0	$0	$0	$1,167,879
Nov-09	$1,183,837	$0	$0	$0	$1,183,837
Dec-09	$0	$0	$75,000	$0	$75,000
Feb-10	$1,213,102	$0	$0	$200,000	$1,413,102
Mar-10	$0	$500,000	$75,000	$0	$575,000
May-10	$1,226,044	$0	$0	$0	$1,226,044
Sep-10	$1,272,804	$0	$0	$0	$1,272,804
Nov-10	$0	$0	$0	$200,000	$200,000
Dec-10	$1,257,702	$0	$0	$0	$1,257,702
Feb-11	$1,286,234	$0	$150,000	$0	$1,436,234
May-11	$1,280,535	$500,000	$0	$0	$1,780,535
TOTAL	**$14,448,428**	**$2,000,000**	**$300,000**	**$400,000**	**$17,148,428**

PRP incentive payments to primary and specialist care providers ranged from $75,000 in December 2009 to a high of $2.1 million in February 2009. Payments were made in 15 of 36 months (41.7 percent) within the engagement window. There were PRP payments made in four months of SFY 2009, six months of SFY 2010, and five months of SFY 2011.



PRP payments within the period included in the examination were at least $5 million per SFY. State fiscal years 2009 and 2010 had similar PRP payment totals at approximately $5.6 million in each. SFY 2011 had the highest level of PRP payments at $5.9 million.



Other Provider Related Incentive / Bonus Payments

During contract analysis, we noted that incentive or bonus payments are available to a number of provider type categories, particularly primary care physicians (PCP). Although most PCPs are reimbursed using a sub-capitation methodology, certain PCPs are eligible to receive a bonus payment of one dollar ($1.00) for each reported Member encounter. The contract between DMS and UHC states the following:

"Encounter Bonus Payment

In order to encourage capitated encounter reporting, a bi-monthly encounter bonus payment of one dollar ($1.00) will be made for each reported Member encounter during which non-billable basic health services (specifically excluding any encounter during which Fee-For-Service procedures were performed) were rendered by Primary Care Provider. Additional information on the encounter bonus payment is included in the Provider Manual. All encounters shall be submitted on the appropriate claim forms to HMO within one hundred eighty (180) days of the dates those services are rendered."

We requested the expenditures for the bonus payment but were informed that such information is not maintained by PHP[26]. Although this payment is referred to as a "bonus payment", it more likely meets the definition of an "incentive payment". Incentive payments are commonly used to incentivize positive behaviors, such as submitting encounter claims on a timely basis. In addition to the encounter submission bonus, we noted that other bonuses may be available to PCPs[27]. During an interview on January 23, 2012, a member of the Partnership Council described three other incentive programs relative to the examination period:

1) Asthma Care – This program is discussed further in Section 4 A-D of our report.
2) Healthy for Life/Child Obesity Clinic - This program is discussed further in Section 1F of our report.
3) Emergency Room Visit Incentive – The Council member stated that "…this incentive was to encourage practitioners to increase their office hours to allow more patients to be able to go to the office instead of the ER. This incentive did not count urgent care visits as an ER visit, although it paid similar to ER. Thus, the Council did not believe the incentive was fair because the providers could not compete equally across the board, so the incentive was removed." Passport did not provide payment data or qualifying criteria for this incentive program. Passport indicated that this ER incentive is a component of the PRP.

Subcontractor / Vendor Related Incentive Payments

Below is a table outlining each subcontractor's general terms of reimbursement. Such general terms were obtained through an analysis of contract templates submitted in response to our requests[28]. Contracts for Dental and Vision services indicated the specific procedures covered. Reimbursement amounts and services rendered may have been adjusted during various periods of the contract term. It appears that three subcontractor contracts contain incentive payment programs. Those subcontractors

[26] Payments are processed and automatically added to the sub-capitation transaction cycle.
[27] Since we did not receive executed provider contracts, we are not certain of the extent to which other bonus payments may be used.
[28] The health plan provided a "contract template" for various service categories, as listed in the table.

include Block Vision, PerformRx, and AmeriHealth Mercy Plan (AMHP). Incentive payments attributable to the Block Vision contract were discontinued prior to the engagement window.

Subcontractor Name	Services Rendered	Base Reimbursement Methodology	Rate Details & Other Notes
Block Vision	Vision Services	Capitation	$3.48 PMPM under 21; $1.72 PMPM over 21; ***Incentive payments***; Other rates applicable depending on period covered. Incentive payments are not applicable – outside of the examination window.
PerformRx	Pharmacy Benefit Manager	Cost + Fixed Fee + PMPM	Actual Provider Payments plus PMPM for administrative expenses; ***Extensive fixed fees paid for Incentives and other services rendered.*** PBM keeps 60% of Medicaid rebate.
AmeriHealth Mercy Plan	Management Services	% of Revenue used to create funding pool for incentives	Start-up costs plus a percentage of total revenue.

PerformRx Incentive Payments

We requested information from PHP regarding the PerformRx incentive subcontractor agreement. PHP was able to locate and provide most of the requested information. However, they indicated that "since we are still in discussions with PerformRx about their performance for the most recent period (Oct. 2010 – Sept. 2011), we do not have the requested document for that time period.

Myers and Stauffer completed interviews of PHP personnel knowledgeable of the PerformRx contract. Below is our summary of those discussions:

- Per PHP personnel, PerformRx would submit a list of incentive threshold percentages for "specialty drugs".
- PerformRx would submit the data at year end.
- PHP staff would review the data to determine qualification.
- Per PHP personnel, PerformRx has been paid for all incentives prior to 2011.
- PHP indicates that the 2011 incentive to maintain the specialty drug trend below one percent was not met. This will result in a significant amount withheld.
- PerformRx would request incentives for each year for approximately $1M annually. The measurement period was October to September of each year.

- The PHP pharmacy director and Chief Medical Officer would review the incentives with subsequent review by the Pharmacy Oversight Committee (not currently used).
- The Pharmacy Oversight Committee oversaw the PBM subcontractor relationship. Incentive payments were approved by UHC staff, usually the Executive VP, with the Pharmacy Oversight Committee as the last line of approval.
- PerformRx won the bid in the early 2000's and replaced the then current PBM. They have not rebid the contract. However, PHP personnel indicated that they are considering a rebid in the future.

The table below illustrates the Incentive Payment Program for PerformRx based on the incentives available from October 2008 through September 2010:

Indicator/Criterion	Deliverable	Incentive Payment
<u>Trend Management</u> Limit the rate of increase in PMPM expenditure for "specialty" drugs to at or below 18% for the 2008-2009 contract years. "Specialty drugs" are defined as: (i) all injectable medications having an ingredient cost of more than $500 per month and/or per treatment that are either self administered, administered at a physician's office by a health care professional; and (ii) oral drug products having a monthly and/or prescription ingredient cost of more than $500.	Measurement of percentage	$250,000 in 2009 $200,000 in 2010
<u>Data Warehouse Integration</u> PBM integrates Passport Health Plan's pharmacy, medical, dental, lab, vision and behavioral health data into one data warehouse. PBM provides a web portal technology to support Passport Health Plan and its members as well as providers to access information to improve quality. It will be Passport Health Plan's responsibility to provide the data to PBM	n/a	$800,000 in 2010

Indicator/Criterion	Deliverable	Incentive Payment
<u>Quality Initiatives</u> In collaboration with Passport Health Plan and ikaSystems, integrate pharmacy prescribing opportunities into the Plan's real-time HEDIS product by: • Identifying the Plan's top five generic or alternative drug prescribing opportunities. • Develop algorithms and provide them to ikaSystems. • ikaSystems will integrate the results into their web-based reporting product • Generate generic or alternative preferred products prescribing opportunities for PCP panel member every two weeks including all prescriptions members are receiving regardless of the prescribing provider. • Every six months evaluate the Plan's data to identify if the top five opportunities have changes. If so, new algorithms will be provided to ikaSystems and integrated into the tool.	1. Provide impact report on a monthly basis. 2. Provide the target drugs for coding. 3. Build the intervention algorithms. 4. Test the system and verify readiness for implementation. 5. Measure generic or alternate drug switches. 6. Update system with new data.	$800,000 in 2009 $400,000 in 2010

We received PerformRx incentive information for measurement years ended September 2009 and September 2010. The incentives earned for those years were $1,050,000 and $1,400,000, respectively. However, the agreement between PHP/UHC and PerformRx limits the amount to a maximum of $1,000,000 for each measurement year. Based upon information reviewed during the reconciliation of UHC/PHP 2008 financial statements, we noted that PerformRx incentive amounted to $885,012. We were told by PHP personnel that the information for measurement year 2011 was currently in the negotiation process.

AMHP Incentive Payments

Based on documentation received from PHP, the AMHP incentive amounts were calculated based upon percentage of Net Capitation Revenue (one percent in 2008, one percent in 2009 and one-half percent in 2010). Total Capitation Revenue is reduced by any of the below listed items to arrive at Net Capitation Revenue:

- Managed Care Tax @ 5.5 percent
- Hospital Tax @ $1,250,000 per month
- Safety Net Payments
- GME Payments
- Kosair IOA Payments
- Urban Trauma Center Payments

Total AMHP incentives (pool of funds) were calculated at approximately $6.4M in 2008, $6.5M in 2009 and $3.4M in 2010. However, we understand that the 2010 incentive payment amount was not paid to AMHP. During discussions with PHP the following was represented:

> *"…in 2010 AMHP walked away from the incentives. Due to a number of circumstances, AMHP decided not to pursue. APA audit, AG audit, etc so they just decided it was in their best interest to walk away from these. ."*

The pool of funds calculated above was split equally between two areas:

The first area was Quality Measures. According to PHP personnel, there was an initial quality subsidy of $500,000 carved out and paid at the beginning of the year. The balance of the quality portion was then split into four components tied to a HEDIS measurement. These measurements were agreed to each year in advance. Prior year results were used as a baseline. The measurement had to change by a certain amount in order to qualify. The change percentage was also agreed upon in advance.

The second area was Operational Measures. In our conversation with PHP personnel, we learned that Operational Measures varied each year and were initiative or project related. PHP would require AMHP to complete various projects. This portion was dedicated to performance measures. The measurements used were either an "Administrative Grid" or "Scorecard" that would indicate measures and targets.

We did not receive the below information for 2008 or 2010. Below is a table that illustrates the 2009 incentives earned by AMHP for both Quality and Operational Measures, as obtained from the January 11, 2012 PHP Board of Director minutes.

Measure	Performance	Withhold or Incentive Earned
2009 Medicaid Quality Measures:		
Well child visits 3-6 years: Goal = 76.21%	GOAL MET: Performance = 76.70%	$765,074
Dental screening: Goal = 53.31%	GOAL MET: Performance = 57.95%	$765,074
Nephropathy screening: Goal = 81.35%	GOAL MET: Performance = 85.57%	$765,074
Cervical Cancer Screen: Goal = 69.83%	GOAL NOT MET: Performance = 67.53%	$0
2009 Medicaid Operational Measures:		
Provider Satisfaction	GOAL MET: Based on surveys, overall practitioner satisfaction increased from 81 percent to 87 percent. For facilities, all providers responding to the survey rated their overall satisfaction with the health plan at 100 percent.	$100,000
Provider Primary Care Providers capability to receive care gaps/clinical alerts identified through ikaProQI at the time of real-time eligibility checks via Navimedix.	GOAL MET: Provider communication issued December 21, 2009. With Member Care Gaps via NaviNet, each eligibility transaction automatically displays a pop-up notification if the respective member is due to receive one of several preventative care services.	$865,074

Measure	Performance	Withhold or Incentive Earned
Provide Primary Care Providers capabilities to auto generate written reminders/calls to members in support of the Provider Recognition Program and health outcome improvements.	GOAL MET: Provider communication issued December 29, 2009; ikProHEDIS+ "Generate Letters" automatically produces individualized, member-friendly reminders to the Primary Care Provider panel members who are due for one or more of several health services.	$692,059
Achieve 2009 administrative goals identified on scorecard.	27 out of 29 Quarterly/Annual Goals Met: For two quarters, the retro inpatient turnaround goal was not achieved.	$1,771,910

During an interview with PHP personnel, we requested a description of the approval process for authorizing payments to AMHP. We were informed as follows:

> *An Executive VP would review the information. AMHP would present an analysis or summary to show how they did on incentives. No one knows what [Executive VP] did with that information. David Stanley would get approval from [Executive VP].*

In response to questions regarding potential conflicts of interest, we were informed that AMHP legal counsel would take the lead on AMHP contract negotiations and "purposely not involve local staff". David Stanley indicated that he would answer some questions or provide information but did not participate in active negotiations. It was also represented that the PHP Board had the final approval, primarily the Chairman, Executive VP Larry Cook, Tom Luber (outside counsel) and some involvement from the Oversight Committee.[29]

During on-site interviews on September 13, 2011, we learned that AMHP had received an incentive payment based on achieving the required performance metrics related to the Healthcare Effectiveness Data and Information Set (HEDIS), which is a set of performance measures developed by the NCQA. We were informed during the interview that the incentive payment received by AMHP was subsequently disallowed. We requested additional information regarding the payment and disallowance. Below is an excerpt from documents submitted by AMHP[30].

[29] Although local health plan staff may not have been involved in the negotiations, AMHP legal staff may have a similar risk for a potential conflict of interest for related party transactions.
[30] AmeriHealth Mercy Health Plan, Memorandum from Barbara Jones, May 7, 2010.

On January 5, 2010 and January 6, 2010, Human Resources (HR) and Corporate Compliance (CC) received reports from AMHP associates in Kentucky identifying concerns about the 2009 NCQA HEDIS submissions. It was alleged that inaccurate data was submitted to NCQA, that UHC's incentive payment to AMHP was based upon that incorrect data, and that AMHP staff was about to submit a misrepresentation about the data to the KY DMS. HR and CC immediately launched an investigation of the matter. The compliance component of the investigation focused on whether erroneous data was submitted to NCQA, UHC and/or the state. Issues of ethics and integrity were considered; additionally, leadership and other HR related issues were considered.

Upon conclusion of the investigation, it was determined that an ikaSystems (ika) software problem resulted in an inaccurate translation of the claims load data into ika's system. Instead of pulling both the revenue and CPT codes for the hybrid samples, only the revenue codes were pulled. This resulted in inaccurate member level data. These inaccuracies were discovered three weeks prior to the NCQA due date. Staff decided, without consulting others at AMHP or UHC, to submit the inaccurate data. This data was used to establish the plan's 2009 NCQA ranking and UHC's incentive payments to AMHP. At the time of the submission, staff concluded that even with the error, the inaccurate submission would be within 1% of the true result. Data was rerun during the investigation and it was concluded that several measures were impacted by the software error. In some cases rates were under-reported to NCQA and in others rates were over-reported. Where over-reporting occurred, the error rate ranged from less than 1% to 2%. To the extent rates were over-reported; they were within the NCQA allowable margin of error. Overall, PHP's NCQA ranking was not inflated by the use of the inaccurate data. Likewise, although UHC's incentive payments were based on inaccurate data, the margin of error for the incented measures ranged from less that 1% to 11/2 %. These differences also fell within generally acceptable margins of error.

An independent firm, Attest Health Care Advisors, LLC, was retained to review the 2009 KY HEDIS process and to verify the findings of the investigation. Attest performed a review of the data and concluded that no material bias exists in the PHP HEDIS rates reported in 2009.

During and upon conclusion of the investigation, UHC was made fully aware of the facts surrounding the 2009 HEDIS submission and decided to accept the rates as reported by ikaSystems.

Ultimately, it was concluded that there were no findings of fraud or intentional misrepresentation. Ethical and HR issues were identified and appropriately addressed. It was recommended that there be corporate oversight of the KY HEDIS process going forward. Management accepted that recommendation and has put several reporting and control mechanisms in place to prevent a reoccurrence of the issues identified.

On January 24, 2011, a Consent Judgment and Assurance of Voluntary Compliance document was entered in the Franklin Circuit Court, Case Number 11-CI-123 (Commonwealth of Kentucky, *ex rel.* Jack Conway, Attorney General v. AmeriHealth Mercy Health Plan). The Consent Judgment and Assurance of Voluntary Compliance included a full and final settlement of the Commonwealth's claims and required a Settlement Amount be paid by AMHP in the amount of $2,032,758.

In 2011, the consulting firm Crowe Horwath was engaged by PHP to review the calculations and supporting documentation for AMHP's 2009 incentive payments. Below is the conclusion of their final report dated December 15, 2011:

> *"We were engaged to review documents provided by AMHP in support of AMHP's incentive payment calculation to Passport Health Plan (PHP) and Passport Advantage (PAD). On June 15, 2011, we provided you with our initial findings which stated that we were unable to confirm the accuracy of the calculation due to unsupported schedules, report errors and discrepancies within the documentation provided. After discussions between you and AMHP it was decided that a sample population would be identified for several of the metrics and supporting documentation would be provided to us for review. The additional documentation was provided on November 28, 2011.*
>
> *Based on our review of the additional sample documentation, it appears that the documentation supports the reports and schedules for the various metrics as described above. Although we found errors and discrepancies in the additional documentation, the results of these errors and discrepancies did not impact the final calculation. Since a limited sample was identified and our opinion is based on this limited sample, we must assume that the sample is representative of the entire population when concluding that the incentive appears to be calculated properly and that the statistics represented and utilized in the calculation are fully supported and calculated correctly and represent the services provided by AMHP."*[31]

[31] From report issued by Crowe Horwath dated December 15, 2011.

Observations, Findings or Recommendations Related to Incentives

1) As described within PR 89.0, the PRP approval sign off includes the following individuals, presented in the order of the approval process: "Manager of Reporting & Data Analysis, AVP of Quality Improvement, PRP Rep, Manager of Provider Services, AVP of Provider Relations, Chief Financial Officer, Executive Director with copies going to VP of Medical Management, Director of Medical Management/Care Coordinator, and Manager of Provider Relations."

   The approval procedure for incentive payments based on PR 112.0 includes the following individuals, presented in the order of the approval process: "Executive Director, Chief Financial Officer, VP of Operations & Contracting, AVP of Provider Relations, Manager of Provider Services, PRP rep, with copies to VP of Medical Management, AVP of Quality Improvement, Director of Medical Management/Care Coordinator, Manager of Reporting & Data Analysis, and Manager of Provider Relations, the PRP [Senior Data Analyst] will submit all measure details and specs with each approval packet."

   PR 89.0 and PR 112.0 do not appear to include procedures to identify excluded providers (i.e., providers that are not eligible to participate in Medicaid or Medicare according to the DHHS Office of Inspector General), providers with open accounts receivable, or providers under investigation prior to distributing funds. Section III of the policy indicates that payments to terminated providers will be "reviewed on a case by case basis." PHP provided the following assurances to DMS:

   > *"Yes, we do check the excluded provider list on the DMS web site. We compare the DMS excluded provider list against our Facets system on a monthly basis."*

2) Although both PR 89.0 and PR 112.0 include performance metrics that must be achieved in order to qualify for an incentive payment, the "minimum reductions" require only a modest improvement in order to qualify. We do not have enough information to determine whether the minimum reduction levels are established at an appropriate and beneficial level (i.e., with a positive return on investment).

3) The PCP workgroup has oversight responsibilities for the primary care PRP. Many of the physicians on the PCP workgroup are eligible to receive payments under the primary care PRP, making a potential environment for a conflict of interest. However, many of the participants that we interviewed indicated that detailed level data were never reviewed during PCP workgroup meetings.

4) 907 KAR 1:705 Section 6 requires that incentive payments "shall be an amount up to one (1) percent of the capitation payment and made annually by the department." PR 89.0 does not include information about how the funding pool is developed, and whether those payments are within the requirements of Section 6. Although PR 112.0 specifies the funding pool amounts, the policy does not indicate whether those payments are within the requirements of Section 6. It is not clear whether the requirements in 907 KAR 1:705 are exclusive to incentive payments made by DMS to a managed care entity or if the provisions extend to the incentive payments made by a managed care entity to its subcontractors.

5) The terms "bonus" and "incentive payment" seemed to be used interchangeably in PHP policy PR 112.0. Those terms should be clarified and utilized appropriately.

6) Based upon our review of provider contract templates, certain PCPs are eligible for bonus or incentive payments based on utilization and other practice characteristics. It appears that the PCP provider category may be eligible to receive a bi-monthly incentive payment to submit encounters detailing the PMPM services provided. However, there appears to be no requirement that encounters be submitted. Not requiring encounter submission appears contradictory to the goal of receiving encounter claims, which is reinforced by offering incentive payments.

7) "Bonus" and "incentive payments" are included in both subcontractor/vendor contracts and health care provider contracts. Such payments can be effective at producing savings and rewarding positive behavior. If not carefully evaluated and monitored, there may be limited value realized for the additional reimbursement. Incentives and bonus payments should be considered in relation to the value of the alternative.

8) The pharmacy benefit manager, PerformRx, receives reimbursement for actual provider payments, plus a PMPM amount for administration, fixed fees for incentive payments and other services provided and they retain 60 percent of the Medicaid rebates received by PerformRx. Because PerformRx is a related party to AMHP, and because AMHP held key management positions within the health plan, there is a potential increased risk that AMHP management personnel may have been involved in contract negotiations with PerformRx. PHP indicated that the contract negotiations were reviewed by an outside consultant.

9) The costs and benefits of incentive programs should be carefully considered to ensure that the Commonwealth receives the greatest value from these initiatives. The intent of the incentive programs should be to (among other factors):

- Increase access to patients
- Incentivize primary care and specialist to accept new patients in outlying areas
- Increase quality of care
- Improve patient satisfaction
- Efficiently manage the care delivery of Passport membership

It is our observation that to incentivize by measuring improvement in these areas is beneficial if monitored, tracked and quantified in a manner that is approved by all parties involved. Incentives must be designed to reduce or avoid cost, or change behavior such that the change represents value to the program. If not structured properly, and without value driven metrics, incentive payments are simply another way to redistribute Medicaid funds.

10) There may be a risk that certain key health plan personnel (either corporate or local) participated in contract negotiations with related parties for contracts in effect during the audit window. Since the transition of embedded AMHP staff to UHC, the risk for future conflicts with related parties (i.e., PBM and family planning subcontractors) has been reduced. However, UHC should ensure that its conflict of interest policies are comprehensive, current, reinforced by management, and put into practice, to ensure the level of transparency requisite of a provider sponsored health plan. Any related party transactions should be reported to DMS prior to the execution of any contractual arrangements or payments made.

11) As described above, carefully designed incentive programs can be extremely valuable in a Medicaid health plan environment. However, we were unable to identify any criteria that were used to create the incentive programs. Many of the non vendor related incentives appear to have been requested by health plan management, without providing anything more than anecdotal information regarding their benefit. Similarly for vendor related incentives, we were unable to identify criteria used in establishing the programs. Health plan staff described that discussions were held among the parties and the programs were approved by the board. However, we cannot determine whether the incentives created value to the program. We observed that many of the incentives were easily obtainable, and were based on goals uncommon to Medicaid incentive plans. Certain incentive amounts appear to be high relative to the qualification criteria. However, without an understanding of the benefits (i.e., how costs were avoided or reduced) of the incentives it is not possible to definitively determine if those incentive amounts were worth the payment. PHP has indicated that it believes that the costs associated with the incentives are consistent with national averages.

Objective 3A-C: Analysis of Expenditures

The key activities related to this objective include:

A. Examine payments made to providers for non-patient care giving responsibilities / activities.

B. Document expenditures that may be broadly categorized as health services that are not specifically Medicaid services.

C. Evaluate the appropriateness of non-direct care expenditures.

Data Collection

To complete these activities, Myers and Stauffer met with DMS to prepare an effective strategy to obtain the universe of fee-for-service and Passport claims, member eligibility data, provider files and other financial data required to complete the tasks of this objective. We conducted conference calls on September 28, 2011, with Peter Davidson from PricewaterhouseCoopers, LLP (PwC), the contractor responsible for providing capitation rate range development services during the examination window, and with Marilynn Hartman from HP on September 26, 2011, the Commonwealth's fiscal agent contractor, to discuss the data request. Following those calls, HP provided numerous files from which we built a relational database of claims and transactions, including capitation to Passport, encounter claims, and fee-for-service payments made by Passport. HP provided control totals with which we were able to confirm that we received a complete data set.

Myers and Stauffer obtained from AMHP and HP data dictionaries; companion guides; edit and audit lists, descriptions and dispositions; full descriptions of the claim adjustment processes, and valid values. We conducted conference calls with Passport and its subcontractors responsible for encounter submissions on January 20 and January 23, 2012 to gain a thorough understanding of the encounter submission and adjustment processes.

Myers and Stauffer did not modify and/or complete additional procedures to correct data files or layouts, fields, numeric values, valid values etc, to get the data into a format that could be used for analysis. Claims requested for this initiative included those with dates of service from July 1, 2006 through June 30, 2011.

All information requested, submitted, or exchanged during the course of this engagement was completed using a Secure File Transfer Protocol (SFTP) provided by

Myers and Stauffer. Unless otherwise authorized in advance or specifically requested, we did not accept hard copy data or information that contains Protected Health Information (PHI). Myers and Stauffer did not accept electronic PHI (ePHI) submitted by e-mail, or on other non encrypted media such as flash drives, laptops, or portable hard drives.

Accuracy and Completeness of the Data

Insufficient information was available to determine the completeness of the encounters being submitted by Passport to the Commonwealth's fiscal agent contractor (Hewlett Packard [HP] Enterprise Services). It is not clear what processes, if any, Passport has in place to evaluate the level of completeness of the encounter data being submitted by its subcontractors on behalf of the health plan. We performed a high level comparison of the medical expenses reported on Passport's medical loss ratio (MLR) reports for the period 2008 through year to date 2011 to assess the completeness of the encounters. The results, however, indicate a significant variance in these two elements which require further investigation to resolve.

Non-patient Care Giving Payments

We conducted interviews with various members of Passport staff, assessed the policies provided by Passport as well as a number of provider contract templates, in order to identify the risk that payments could be made to providers that were not directly associated with the provision of patient care. A number of these types of payments appear to have been identified. We noted earlier in the report that Passport provides for a per encounter bonus payment to capitated providers as an incentive to submit encounter data to the health plan. It is not clear what activities, if any, Passport engages in to assess the level of completeness or accuracy of the encounter data being submitted by providers to the health plan.

We noted that both the contract between DMS and Passport, as well as Passport's own internal acceptance rates, require that at least 95 percent of the encounters submitted by Passport be accepted by HP by the 15th of the following month. However, it does not appear that any processes are in place at Passport to ensure that 100 percent of the encounter records are submitted to Passport by providers and that 100 percent of those encounters records are then submitted to DMS.

Passport also makes utilization performance payments to primary care providers with an average of at least 150 members in the final three months of the reporting period. These payments are discussed in more detail in the provider related incentive payments section under Objective 2E.

For each of the payments mentioned above, it appears that these costs are included in the medical expense category of Passport's MLR reports. It is unclear to us whether the inclusion of such incentive payments, which appear to be discretionary

expenditures, is a permissible activity under the terms of the contract between the Department and UHC.

Non-covered Services

Passport's Member Handbook explains the covered benefits available to its members. In addition, certain services and medications are not covered by the health plan. These services and medications include:

Services Not Covered

- Services, medicines and medical equipment not medically necessary.
- Abortions, unless the life of the mother is in danger, or in the event of rape or incest
- Cosmetic surgeries and medicines
- Long-term institutional care
- Experimental procedures
- Hysterectomy, if performed for hygiene or sterilization reasons only
- Infertility treatment (medical or surgical)
- Oral surgery that is cosmetic.
- Paternity testing
- Personal care items such as hair brushes, shampoo, toothpaste, feminine hygiene products, etc
- Personal items or services while you are in the hospital, such as television or telephone
- Funeral or burial costs
- Reversing or changing back surgeries like tubal ligation.
- Making mentally ill patients or persons in the hospital sterile
- Sex change operations.
- Specialty care not set up by [a] PCP

Medicines not covered by Passport Health Plan

- Cosmetic products
- Stop-smoking products
- Medicines to [aide in becoming] pregnant
- Medicines used for research that are not approved by the Food and Drug Administration (FDA)
- Medicines not medically necessary
- Erectile dysfunction drugs
- Herbal supplements

We did not find evidence during the examination that these items were being paid for by Passport nor does it appear that any related costs are included in medical expenditure reports provided to DMS.

Claim Validation

We selected a sample of approximately 250 Passport or benefit subcontractor claim payments to providers in order to perform a validation of certain elements within an encounter claim. Sampled claims were selected from the encounter data provided to the Commonwealth's fiscal agent contractor. The validation process included randomly selecting claims, confirming that the encounter was present within the PHP MMIS, that information on the encounter matched the information in the PHP MMIS, and that the information on the encounter matched the providers' records. The claim validation sample included the following:

- **50 Pharmacy Claim Lines** (Minimum Fields: Claim Number, Member ID, data dispensed, NDC, quantity, billed amount, paid amount, prescribing provider ID)
- **100 Hospital Claim Lines** (Minimum Fields: Claim Number, Member ID, DOS, revenue/procedure code, modifiers, billed amount, paid amount, provider ID)
- **100 CMS 1500 Medical Claim Lines** (Minimum Fields: Claim Number, Member ID, DOS, revenue/procedure code, modifiers, billed amount, paid amount, provider ID)

Claims were randomly selected from all non-zero final paid claims for the SFY ending June 30, 2011. Claims were selected from the most current period available in order to aid providers in performing the validation.

We provided the selected claims to Passport and requested that they 1) provide screen shots from the FACETS system to confirm that information reported to HP agreed to the information shown in Passport's claims processing system, and 2) send the sample claims to the appropriate providers for independent validation. This process required providers to confirm (using checkmarks on a pre-populated form) certain elements on the claim they submitted, which was subsequently adjudicated by Passport (AMHP or one of Passport's other subcontractors).

We provided the sample claims to Passport via a secure FTP site on January 20, 2012, and provided detailed instructions and a validation template to Passport. We requested validation results by February 6, 2012. Passport submitted documentation related to this request on February 24 and February 28, 2012. Based on Passport's responses, certain claims were removed from the original sample. The table below shows the related response rates.

Claim Type	Sample Size	Claims Removed from Sample	FACETS Information Submitted	Provider Response Submitted	Provider Response Rate
Pharmacy	50	0	50	20	40%
Hospital	100	0	90	15	15%
CMS1500	100	21	0	16	20%

In reviewing the responses from Passport and the providers we noted certain apparent discrepancies in the claims data. It is unclear whether these are issues may impact other activities which utilize this information from the MMIS. Findings from the claims validation include the following:

1) The low provider response rate makes calculating the accuracy of the claims data difficult since it is unclear whether the responses received are representative of the potential errors in the universe of claims.

2) Of the approximately 6.8 million Passport pharmacy claims included in the MMIS universe, 5.6 million (or 82.4 percent) contained a billed amount that was equal to the paid amount. Generally, the billed amount (sometimes referred to as Usual and Customary, or "U&C") reflects a provider-specific mark up and is the price charged for a cash-paying customer. Payor-specific negotiated price adjustments or fee schedules are not typically reflected in this amount. We compared this information to the screen shots for the sample claims provided by Passport and in no case did the billed amount equal the paid amount.

3) There were 2,405 pharmacy claims included in the universe where the billed amount on the claim was zero but the claim paid greater than zero. All of these claims included paid dates prior to May 2007.

4) One response received from a hospital provider indicated the amount billed on the claim was incorrect. When we examined the screen shot of the claims data included in FACETS, it appears that the encounter data from HP included only the billed amount from the first line of a multiple detail line claim. We evaluated the screen shots from FACETS for the other hospital claims included in the sample and noted that in several other instances the encounter data contained a billed amount which reflected only the charges from a single line on the claim, in most cases associated with a room and board revenue code.

√ Observations, Findings or Recommendations Related to the Analysis of Expenditures

1) It is not clear what processes, if any, Passport has in place to evaluate the level of completeness or the accuracy of the encounter data being submitted to DMS by its subcontractors on behalf of the health plan. We recommend that PHP develop a plan to ensure complete and accurate encounter data is available to DMS.

2) It is not clear what activities, if any, Passport engages in to assess the level of completeness or accuracy of the encounter data being submitted by providers to the health plan. Since many of the capitated providers appear to be paid incentives to submit timely encounters, we recommend that PHP develop a plan to ensure complete and accurate encounter data is available to DMS.

3) We noted variances between the medical expenses reported on encounter claims to the medical loss ratio data submitted by the health plan. We recommend that PHP investigate, reconcile differences, and report findings to DMS.

4) The low provider response rate makes calculating the accuracy of the claims data difficult since it is unclear whether the responses received are representative of the potential errors in the universe of claims. There are tremendous benefits that can be realized from a claims validation study. Therefore, we recommend that Passport continue to pursue responses from providers, and update DMS with the results. In response to this recommendation, PHP indicated the following:

> *We will put a process in place to periodically conduct an encounter review with our providers. The process will be similar to the process we followed during the audit when we were requested to conduct the claim validation.*
>
> *On a periodic basis (e.g., annually), we will notify providers of our claims validation project. To perform the claims validation, we will pull a sample of medical, dental, pharmacy and vision claims. Each claim in the sample will be reviewed to note whether the claims were for services not covered by PHP and billed to DMS. After the claims have been reviewed and notations made to the claim log that accompanies the claim sample, the claims log and sample claims will be sent to the providers for their review. Providers will be instructed to review the sample claims and respond on form whether the information maintained by PHP is correct or incorrect. If*

the information is not correct, PHP will research the claims sample to determine if the incorrect information pertains to one claim or reflects a problem with several claims. Appropriate action will be taken to correct the claim or claims.

5) Of the approximately 6.8 million Passport pharmacy claims included in the MMIS universe, 5.6 million (or 82.4 percent) contained a billed amount equal to the paid amount. Generally, the billed amount (sometimes referred to as Usual and Customary, or "U&C") reflects a provider-specific mark up and is the price charged for a cash-paying customer. Payor-specific negotiated price adjustments or fee schedules are not reflected in this amount. We compared this information to the screen shots for the sample claims provided by Passport and in no case did the billed amount equal the paid amount. We did not note any issues with the paid amounts. While the paid amount is a critical element for both rate setting and financial reporting reconciliation functions, we recommend that PHP follow-up with DMS, HP, or other entities on this matter and correct the encounter files as appropriate.

6) There were 2,405 pharmacy claims included in the universe where the billed amount on the claim was zero but the claim paid greater than zero. All of these claims included paid dates prior to May 2007. We recommend that PHP follow-up with DMS, HP, or other entities on this matter and correct the encounter files as appropriate.

7) One response received from a hospital provider indicated the header amount billed on the claim was incorrect. When we examined the screen shot of the claims data included in FACETS, it appears that the encounter data that HP has includes only the billed amount from the first line of a multiple detail line claim. It is unclear whether this is an isolated issue and to what degree this may impact other activities which utilize this information from the MMIS. We recommend that PHP follow-up with DMS, HP, or other entities on this matter and correct the encounter files as appropriate.

Objective 4A-D: Grant Award Process

The objective of this analysis includes the following components:

Examine the grant award process by Passport, AmeriHealth Mercy and other subcontractors.

A. Review and identify all grants awarded by Passport or its subcontractors.

B. Document the process to establish grants or donations.

C. Review the methodology of the grantee selection process to determine, at a minimum, the following:

   a. Competitive or non-competitive award process

   b. Composition of any selection committee

   c. Questionable practices related to selection methodology

D. Document the grant monitoring process including, but not limited to, the following:

   a. The methodology used to ensure grant funds were spent appropriately and for the intended purpose of the grant.

General Approach to Analysis

Myers and Stauffer developed a data and documentation request that was sent to Passport Health Plan. This request solicited information regarding any grants that were awarded by PHP during the engagement window. Work plan activities for this deliverable included analysis of the supporting/authorizing provisions of the Medicaid State Plan, the base contract between The Commonwealth of Kentucky Department for Medicaid Services (DMS or Department) and University Health Care, Inc. (e.g. "Contract between DMS and UHC"), the Kentucky Administrative Regulations (KAR), and the Code of Federal Regulations (CFR). We also analyzed reports and other source materials that were submitted by PHP.

We attempted to analyze the process used by Passport to receive grant requests, and the corresponding award process, including any guiding parameters such as the Medicaid State Plan or Contract between DMS and UHC. We analyzed applicable policies and procedures, examined board meeting minutes, and conducted interviews with certain health plan personnel.

Guiding Parameters for the Grant Award Process

The requirements of the Medicaid State Plan, the Contract between DMS and UHC, the Kentucky Administrative Regulations, the Code of Federal Regulations, Medicaid provider manuals, and PHP policy and procedure manuals relative to the grant award process are excerpted and included in the sections below. To enhance readability, we have modified line spacing, inserted indentations, removed superfluous text, and inserted acronyms where appropriate. We did not modify language or section/title/paragraph references, such that excerpts may be easily cross-referenced back to the corresponding original documents.[32]

Medicaid State Plan Sections

A review of the Medicaid State Plan did not identify sections and/or requirements related to grants.

Contract between DMS and UHC

We reviewed the Contract between DMS and UHC' "Medicaid Health Care Contractor Contract," for the years 2009, 2010, 2011, and 2012. Below are excerpts from these contract requirements specific to grants awarded and/or distributed by Passport. Other than the disclosure described at Section 16.21, we did not locate specific requirements related to grants.

Page	Section	Contract Requirement
140	16.21	**Disclosure of Certain Financial Information** The Contractor agrees to provide the Department within thirty (*sic*) (30) days of contract execution a business plan that outlines proposed annual expenditures under the contract for items including but not limited to proposed budgets for salaries, bonus, other compensation, travel, other expenditures (i.e. sponsorships, grants, donations, insurance cost and medical expenses) and other items in APA's report.

[32] Acronyms and reference word inserts can be identified by brackets "[ ]". Areas where superfluous text has been removed can be identified by three periods "…". In some cases we inserted spaces between lines to improve readability. Emphasis added can be identified by underlined text in italics.

Kentucky Administrative Regulations

We analyzed Title 907 of the KAR to identify potential regulations related to grant awards and distributions. We did not locate any applicable regulations within Title 907 of the KAR.

Code of Federal Regulations

We analyzed 42 CFR 438 (Medicaid Managed Care) to determine the applicability to grant awards and distributions. We did not locate any applicable requirements within the CFR.

Policies and Procedures

We reviewed the Passport Health Plan Provider Manual, updated September 2011, and found no mention of grants, including those grants for indigent care and Improved Health Outcomes Program (iHOP). Additionally, we reviewed policies provided by UHC. We noted a "Grant Policy" was created on July 29, 2011. The purpose of the policy is to establish guidelines that are to be followed when an application for a grant is submitted to Passport Health Plan. This policy applies to all grants. A grant, by the policy's definition is:

> *"A monetary award to an organization, provider, company or other entity (collectively referred to as "organization" throughout this Policy) for the purpose of assisting the organization in conducting research or implementing programs that encourage innovation and research. These programs should improve health outcomes for Kentucky Medicaid recipients and the uninsured and that provide access to quality healthcare services for Kentucky Medicaid recipients and the uninsured."*

Requests for Data and Documentation

On September 2, 2011, we requested from Passport Health Plan a detail listing of all non-claim-specific payments made by PHP during the engagement window (i.e., July 1, 2008 through June 30, 2011). Specifically, the request included the following components:

- Detail general ledger for distributions to shareholders/owners/affiliates from January 2008 through current;
- Detail listing of all non-claim-specific supplemental payments, including grants; and,
- Detail supporting grants including formulas, contractual provisions, guidelines, state plan amendments or other regulation/statute authorizing the payment.

For purposes of the state comparison survey (please also see Objective 1B) an additional request for information related to grants was sent to the health plan on September 15, 2011, which requested information for the period between July 1, 2010

and June 30, 2011 (State Fiscal Year [SFY] 2011). Specifically, the survey included the following questions located in Section 3 (Health Plan Contractual Characteristics), questions 28 - 31:

- Does the contract with the Medicaid agency include limitations or restrictions on health plan issued/awarded grants? Does the health plan issue/award grants? Please specify contract section and requirements for issuing/awarding grants.
- If the health plan has issued/awarded grants, what was their purpose? What type of entities have been issued/awarded grants? Please specify whether these entities are health care providers, subcontractors, vendors, or other entity, and whether there is any type of ownership or related party relationship to the health plan.
- Total grant payments issued/awarded for twelve (12) month period.
- Who within the health plan issues/awards grants? What is the Medicaid agency's role (if any) to authorize grants? What are the responsibilities or obligations of the receiving entity?

Grant Approvals Resulting from Board Activity

Per review of the UHC Passport Health Plan Board minutes for December 11, 2008, it appears the Executive Committee or the iHOP Committee approved the distribution of grants and submitted the minutes from those meetings to the Board for approval. The following grant distributions were noted as approved in the December 11, 2008 Passport Health Plan Board Minutes[33]:

Grant Name/Description	Grant Amount	Date Approval Documented in Board Minutes	Executive Committee Approval	iHOP Committee Approval
Health Department Grant	$500,000	12/11/2008	11/24/2008	None Documented
A coalition in a non-Jefferson County area to address pediatric obesity involving children and their parents	$50,000	12/11/2008	None Documented	12/3/2008
A study involving clinical skills for early detection of oral cancers in the African-American population	$50,000	12/11/2008	None Documented	12/3/2008
University of Louisville (U of L) School of Nursing - A study on motivational style interviewing for African- Americans with Type II Diabetes	$50,000	12/11/2008	None Documented	12/3/2008

[33] It appears that the Board approved items other than Grant requests/distributions. We noted some potential overlap between the grants and other payment programs.

Grant Name/Description	Grant Amount	Date Approval Documented in Board Minutes	Executive Committee Approval	iHOP Committee Approval
Louisville Emergency Medical Services (EMS) with the Health Department to pilot a program where low acuity triage could be diverted to a primary care facility instead of emergency rooms	$50,000	12/11/2008	None Documented	12/3/2008
An obstetrics and gynecology (OB/GYN) study involving the immediate implantation of an IUD (Intra-uterine device) after delivery to prevent future pregnancies	$50,000	12/11/2008	None Documented	12/3/2008

The UHC Passport Health Plan Board minutes for October 14, 2009 appear to indicate that the UHC Passport Health Plan Board approved the distribution of the 2009 grants. The following grant distributions were noted in the October 14, 2009 Passport Health Plan Board Minutes and approved[34]:

Grant or Appropriation Name/Description	Grant/Appropriation Amount	Date Approval Documented in Board Minutes
Grace House	$250,000	10/14/2009
Bridgehaven Grant	$50,000	10/14/2009
Additional payments to Departments of Health that have home health or school based services (provided historically)	$500,000	10/14/2009
Grant to Department of Health (provided historically) (will hold idea of additional $500K until after state contract)	$500,000	10/14/2009
Continuation of Kentucky Children's Health Insurance Program (KCHIP) Outreach Staffing Appropriation	$500,000	10/14/2009
Camp Courageous	$25,000	10/14/2009

We identified information on the Passport Health Plan website showing the following iHOP grants, although not always documented in the Board Minutes, were distributed in the period 2008-2010:

[34] There is a potential that certain "grants" identified by PHP may not be "grants" as that term is used and defined by the Department.

Grant Year	Name of Grant	Description of Grant	Date Approval was Documented in Board Minutes
2008	**Clinical Skills for Early Detection of Oropharyngeal Carcinomas in High-Risk Urban African American Population: Development of a Novel Educational Intervention and Educational Assessment Strategy.**	The study objective is to develop and test an educational intervention aimed at oral health practitioners' ability to improve recognition of early-stage oropharyngeal cancers. Thirty Louisville-based oral health practitioners will be targeted to participate in a continuing education program on oral health utilizing standardized patients. Following this work shop standardized patients will visit the oral health practitioners practice for unannounced new patient visits to determine the effectiveness of the training at fixed intervals (3, 6, and 9 months) post intervention and education session.	12/11/2008 for up to $50,000
2008	**The Effects of Motivational Interviewing on Type 2 Diabetes Management in African American Adults: A Pilot Study.**	The study objective is to determine the effects of a motivational interviewing intervention on adherence to prescribing treatment regimens, diabetes markers, and number of unscheduled health care visits among African Americans with type 2 diabetes mellitus. This study is a randomized, controlled trial with a planned enrollment of 30 participants to the intervention group and 30 participants to a usual care group.	12/11/2008 for up to $50,000
2008	**A Community Coalition to Help Parents Raise Healthy Confident Children.**	The study objective is to form a community coalition to fight childhood and adolescent obesity through a year-long interdisciplinary program. Three components of the program include: 1) physical activity, 2) dietary management and nutritional education, and 3) confidence and self-esteem boosting counseling sessions. Fifty obese children, ranging 5-12 years of age with a commitment of at least 1 parent, will be selected to participate in the program.	12/11/2008 for up to $50,000

Grant Year	Name of Grant	Description of Grant	Date Approval was Documented in Board Minutes
2008	**Louisville Metro EMS** *Priority Solutions Integrated Access Management* (**PSIAM) Pilot Program.**	Study goals are: 1) to implement a pilot program for the alternate triage of patients assessing the 911 emergency medical services system for low-acuity medical concerns; and 2) to evaluate the specificity of a 911 call-processing algorithm for indentifying low-priority 911 medical patients, and for the timely and safe referral of these patients to alternative non-acute sources of medical care. 911 emergency calls categorized as "low-priority" by the Metro-Safe 911 Communications Center will be secondarily triaged by a trained nurse utilizing the pilot PSIAM call-processing algorithm. The nurse will access a database to determine the appropriate and safe alternative referral to existing community resources rather than the emergency dispatch of a 911 ambulance. The PSIAM call-processing algorithm is currently being piloted in London, England; Richmond, Virginia; Houston, Texas; and Oklahoma City, Oklahoma.	12/11/2008 for up to $50,000
2008	**Intra-uterine device placement: a randomized, controlled trial.**	This study is a randomized, controlled trial comparing typical placement of IUD's at six week's postpartum or later and immediate post-placental placement with regards to the rate of success, complications, and patient satisfaction.	12/11/2008 for up to $50,000

Grant Year	Name of Grant	Description of Grant	Date Approval was Documented in Board Minutes
2009	**Aqui Es Donde Nos Encontramos (Here is Where We Meet) Project**	The goal of this project is to develop, implement, and evaluate a community-focused, digital storytelling tool and method, which will enhance ongoing efforts to engage community members developing plans to eliminate health inequities. The specific aims to achieve this objective for the Latino populations served by two neighborhood community centers are: 1. Recruit and train 10 facilitators in using PlaceStories, a digital storytelling methodology, to encourage, support and sustain the Health Equity Dialogue process with these populations; 2. Implement and test the effectiveness of using this specific tool and methodology in expanding the engagement of Latino populations in action planning focused on addressing the social determinants currently limiting their access to prevention and clinical services and on decreasing their exposure to negative systemic issues; and, 3. Collect, analyze and share relevant information about the community's perception of priority issues regarding health inequities and proposed best practices for addressing these priorities.	Grant approval was not documented in Passport Health Plan Board Minutes
2009	**Kangaroo Care Expanded**	This project proposes to increase breastfeeding rates in sixteen Kentucky counties by training healthcare providers to implement Kangaroo Care (KC) at the ten birthing hospitals served by Passport Health Plan. The primary goal is to increase breastfeeding rates in the ten hospitals in the Passport Area from an average of 49% to an average of 55% in 12 months.	Grant approval was not documented in Passport Health Plan Board Minutes

Grant Year	Name of Grant	Description of Grant	Date Approval was Documented in Board Minutes
2009	**Wholesale "Central Fill" Pharmacy System**	The aim of this study is to determine the effects of a Wholesale "Central Fill" Pharmacy system on the Access to an Indigent Prescription Replenishment Program; Kentucky Physician's Care (KCP) Program. The related hypothesis is that by implementing a Wholesale "Central Fill" Pharmacy System an increase will be demonstrated in: 1. The number of participating pharmacies; 2. The speed which participating pharmacies receive their replenished pharmaceuticals; and, 3. The number of participating pharmaceutical companies.	Grant approval was not documented in Passport Health Plan Board Minutes
2009	**Improve use of health services by teen mothers with symptoms of depression through a public health, social marketing intervention.**	The aim of this study is to determine the acceptability, feasibility, and efficacy of a public health, social marketing intervention to improve health care use of teen mothers with symptoms of depression. Exploratory research questions will be utilized to define the market (understand how teen mothers use social media; where they receive health information; who they prefer to receive health information from), in message development (obtain the opinions of teen mothers concerning what the message should be, the image of the message, and how message should be delivered such as Facebook or text message, etc.), and in concept and message testing (pilot testing of the message with teen mothers). Then outcomes related to the public health, social marketing intervention will be measured.	Grant approval was not documented in Passport Health Plan Board Minutes

Grant Year	Name of Grant	Description of Grant	Date Approval was Documented in Board Minutes
2009	**E.A.R.S.: Leading to a better understanding of the educational needs, access issues, resources and satisfaction with care for high risk pregnant women who participate in the Prenatal Task Force Mother's Day Out Program.**	The aims of the project are to lead to a better understanding of the needs and access issues for pregnant, low income women; examine the Mother's Day Out Program (MDO) to improve the satisfaction with care; and explore the unique collaboration and community based partnerships that MDO offers to improve the care for this population.	Grant approval was not documented in Passport Health Plan Board Minutes
2010	**Effects of Educational Intervention on Long-Term Outcomes of Hospitalized Children with Asthma.**	This study will assess the effectiveness of utilizing reinforced asthma education to improve care and reduce the health care costs that result from avoidable morbidity related to asthma in children 5-12 years of age. The main objectives are to: 1) to determine the retention rate of knowledge about asthma and 2) evaluate the clinical status, quality of life and healthcare costs of children with asthma following an educational intervention. A randomized control design will be utilized to assess standardized asthma education versus standard education with an enhanced reinforcement education intervention.	Grant approval was not documented in Passport Health Plan Board Minutes

Grant Year	Name of Grant	Description of Grant	Date Approval was Documented in Board Minutes
2010	**Cost Savings and Improved Access to Health Care with Guardianship.**	The objective of this study is to understand the extent to which guardianship services achieve cost savings and improved access to health care for Medicaid and uninsured populations in Passport Health Plan's Region 3. Project hypotheses are: 1) state guardianship services provided by the Division of Guardianship, Cabinet for Health and Family Services, achieve cost savings and improved access to health care for Medicaid and uninsured populations in PHP's 16 Kentucky counties and 2) functionally disabled Medicaid and uninsured populations in PHP's 16 counties without appropriate guardianship services increase costs and reduce access to care for this population. The study authors will analyze data from the Division of Guardianship to gather in-depth information regarding guardianship services available in PHP's 16 counties. Additionally, the study team will calculate guardianship and Medicaid costs and cost savings to the state and quality of life improvements for the legally "disabled" persons served by the Division.	Grant approval was not documented in Passport Health Plan Board Minutes
2010	**Disease Management Program for Depression.**	This study will pilot a disease management program for Medicaid insured patients with major depressive disorder (MDD) seen in primary care. Specific project aims are: 1) increase the frequency of use of an objective measure for diagnosing and monitoring outcome of patients with MDD treated by primary care clinicians; 2) increase the number of patients with MDD who receive appropriate and adequate treatment for this condition by primary care clinicians; 3) decrease the number of patients who are treated with antidepressants for non-indicated conditions; and 4) pilot use of health care costs as a measure of impact of a disease management program.	Grant approval was not documented in Passport Health Plan Board Minutes

Grant Year	Name of Grant	Description of Grant	Date Approval was Documented in Board Minutes
2010	**Improving Health Outcomes Through a Community Care Navigator.**	The aim of this project is to improve the health outcomes of residents in Region 3 with Passport, Passport Advantage, Medicaid, or no insurance through a disease management initiative designed to reduce 30-day readmissions to Jewish Hospital by 4% over a 12-month period. The demonstration project is modeled after the Coleman Care Transitions Intervention, an evidence-based four-week coaching process that empowers patients to assume greater responsibility and control over their self-care in the community. Improved adherence with prescribed treatment is expected to stabilize or curtail markers of participants' disease and to minimize health care utilization. The project will provide a community care navigator to eligible patients who will serve as a health coach for each patient. The navigator, a registered nurse, will monitor the health status of each patient and work as a coach to improve their ability to manage medications, keep their personal health record, understand the indicators suggesting that their condition is worsening and how to respond, and facilitate follow-up care with primary care providers and specialists.	Grant approval was not documented in Passport Health Plan Board Minutes

Return of Capital

Based upon information received from PHP, the return of original capital was determined by the Office of Attorney General to be inappropriate. Payments totaling $10,484,162 million made to eight facilities were identified as "2008 Return of Capital." Nearly all of these funds will be returned to Passport based on a settlement agreement with the Office of Attorney General. Certain sponsoring organizations were not required to return all or a portion of the funds received.

Indigent Care Grants

In 2008 and 2009, the UHC Passport Board approved the distribution of indigent care grants. These grants totaling $10 Million each year for both 2008 and 2009 were distributed based on ownership interest to the six sponsoring organizations (per December 11, 2008 board minutes and December 9, 2009 board minutes). According to these minutes, the board sought approval from the Department of Insurance prior to approval of the grants and disbursement of funds.

As a result of an investigation by the Office of the Attorney General on behalf of the Commonwealth of Kentucky and DMS, a settlement agreement was reached to return $26.4M of funds relating to Indigent Care Grant payments and return of the hospitals' original equity investment to UHC. Below we have listed some the relevant findings in the settlement agreement:

> *"When Passport filed its Amended and Restated Articles of Incorporation of UHC Newco, Inc. with the Secretary of State for the Commonwealth of Kentucky in October 2002, the entity affirmatively reincorporated itself as a nonprofit entity subject to the restrictions placed on nonprofit organizations, including the provisions of KRS 273.237.*
>
> *KRS 273.237 states, in part: "No dividend shall be paid and no part of the income or profit of a corporation shall be distributed to its members, directors or officers.*
>
> *In and around the fall of 2008, Passport carried an excess capital reserve. The excess capital reserve constitutes the amount of capital reserves over and above the Risk Based Capital reserves that the Commonwealth's Department of Insurance (DOI) required Passport to maintain to function soundly as an insurer.*
>
> *The Attorney General contends that in and around the fall of 2008, Passport's Executive Committee and Board of Directors, the two main governing groups of the organization, addressed the need to reduce its excess capital reserves, particularly in light of ongoing rate negotiations with the Cabinet.*
>
> *There is evidence to suggest that in and around the fall of 2008, as a means to achieve lower capital reserves, the Passport Board of Directors considered the idea of returning the initial capital investment to members, and/or paying grants to members intended to offset or otherwise cover unreimbursed medical care services rendered to indigent individuals by member-affiliated providers or at member-managed hospitals.*
>
> *On December 11, 2008, Passport's Board of Directors voted to award a total of $10M in "Indigent Care Grants" to Passport's corporate-members, pro rata in accordance with their percentage initial capital contribution. These grants failed to consider and had no correlation in amount with the actual amount of indigent care provided by the recipient corporate members.*
>
> *The Attorney General believes that, pursuant to KRS 273.237, Passport, as a nonprofit corporation, was not legally permitted to distribute any part of its income or profit to its members.*

The Attorney General believes the actions of the Passport Board of Directors reduced and diverted assets intended for the provision of health care services to Medicaid beneficiaries, and the restitution of diverted assets to Passport is just and appropriate".[35]

The table below illustrates the amounts due from each of the affected sponsors and repayment plans. According to PHP personnel "everyone is current on their repayments schedule and all monies go back to UHC reserves."

Entity Name	Initial Capital Investment Repaid to be Returned	Additional Indigent Care Grants Issued to be Returned	Total UHC Receivable	Repayment Plan per Settlement Agreement
UPA	$5,383,750	$9,000,000	$14,383,750	1 Payment of $5,383,750 within 10 days of execution of the settlement. 5 Payments of $1,800,000 according to the following schedule: One payment on or before July 31, 2011; one payment on or before July 31, 2012; one payment on or before July 31, 2013; one payment on or before July 31, 2014; and one payment on or before July 31, 2015.
Norton Healthcare	$1,348,581	$2,660,000	$4,008,581	1 Payment of $4,008,581 within 10 days of execution date of the settlement.

[35] Settlement Agreement Document between DMS and the Member Hospitals dated July 20, 2011.

Entity Name	Initial Capital Investment Repaid to be Returned	Additional Indigent Care Grants Issued to be Returned	Total UHC Receivable	Repayment Plan per Settlement Agreement
UMC	$1,313,250	$2,660,000	$3,973,250	1 Payment of $1,313,250 on or before 12/31/11. 5 Payments of $532,000 according to the following schedule: One payment on or before January 1, 2012; one payment on or before January 1, 2013; one payment on or before January 1, 2014; one payment on or before January 1, 2015; and one payment on or before January 1, 2016.
Jewish/St. Mary's	$1,348,581	$2,660,000	$4,008,581	1 Payment of $1,336,195 within 10 days of execution of the settlement. 2 Payments of $1,336,193 according to the following schedule: One payment on or before July 31, 2012 and one payment on or before July 31, 2013.
TOTAL	**$9,394,162**	**$16,980,000**	**$26,374,162**	

According to the Office of the Attorney General dated July 21, 2011 the following was stated regarding the repayment of the above:

> *"The settlement does not require repayment of $2.61 million from one of the investor-members, Louisville/Jefferson Primary Care Associates. The Attorney General determined that the entity used the money to provide healthcare to its target group of patients. In addition, Primary Care Associates would not be financially able to pay back the money it received and forcing it to do so would negatively impact services to the community's most needy residents.*
>
> *UPA, who reached out to the Attorney General's office to cooperate in the investigation, is also receiving a $1.5 million credit in this settlement that will be counted as a portion of the costs of an upgrade to UPA's electronic medical records system attributable to Medicaid patients. The new system will create a care delivery system on par with some of the best in the nation."*

Louisville Primary Care Association (LPCA) Survey

On January 23, 2012, Myers and Stauffer requested completion of a survey for members of the LPCA. Below are the survey questions and responses we have received as of the date of this report:

1) *Please describe how Passport Health Plan is identified on your financials (i.e. as an investment or not at all), and whether that situation remains as of today. If that is not current, please describe when that changed and under what circumstances.*

RESPONSE: Louisville Department of Public Health and Welfare

"The funding the Louisville Metro Government received from Passport is recognized as revenue for the program in the year it is received. Passport expenditures that are incurred during the year apply against that recorded revenue. Any unspent funding at the end of the year remains designated for the Passport program and is carried forward into the New Year. This is how we have always recorded the activity related to Passport and I do not anticipate any changes."

RESPONSE: Family Health Centers, Inc.

"Family Health Centers, Inc. (FHC) classified Passport Health Plan as a HMO Shares Investment under the category Other Assets on the Balance Sheet of the monthly Financial Statements. (FHC's external auditors classified Passport Health Plan as Other Long-Term Investments under the category of Noncurrent Cash and Investments on the Balance Sheets of the audited FHC financial statements.)

The situation has changed. FHC received a check from Passport for the return of the original capital investment totaling $272,500 on December 22, 2008. The $272,500 included a return of the original capital investment of $155,000 and $117,500 for the return of non-cash contributions. Consequently, the HMO Shares Investment/Other Long-Term Investments were moved from investments to cash under Assets on the Balance Sheet for Fiscal Year 2009, and does not appear in subsequent years."

RESPONSE: Park DuValle Community Health Center, Inc.

"Park DuValle Community Health Center, Inc. (PDCHC) classified their investment in Passport Health Plan on the Balance Sheet as Noncurrent

Cash and Investments: Investment in HMO Partnership in their Audited Statements through the fiscal period ended November 30, 2008.

In December 2008 that changed. PDCHC received a check from Passport Health Plan for $272,500 dated 12/22/2008. Those funds represented a return of capital for PDCHC's original investments for $195,000 and the remaining $77,500 was a credit for non-cash contributions.

Our ownership position of this investment is disclosed in a Note in our Audited Financial Statements. In December 2008 the balance sheet account Investment in HMO Partnership was reduced to zero to reflect the Return of Capital described above."

2) *Please identify the amount of the indigent care grant (s) that your facility received, including the month and year of payment and the payment amount for each.*

RESPONSE: Louisville Department of Public Health

"The Metro Health Department did not receive indigent care grants from Passport."

RESPONSE: Family Health Centers, Inc.

"FHC received the following two (2) indigent care grants from Passport Health Plan:

Indigent Care Grant 1--(Dated 12/16/2008) Amount $509,700
Indigent Care Grant 2--(Dated 12/11/2009) Amount $509,700"

RESPONSE: Park DuValle Community Health Center, Inc.

"PDCHC received two Indigent Care Grants from the Passport Health Plan:

Indigent Care Grant: 12/22/2008 in the amount of $250,300
Indigent Care Grant: 12/14/2009 in the amount of $250,300"

3) *Please provide a brief explanation regarding how finds were used (e.g., for primary care, new staff, etc.)*

RESPONSE: Louisville Department of Health

"Not applicable"

RESPONSE: Family Health Centers, Inc.

"The grants were used to pay for the costs of uncompensated primary care to uninsured patients. Approximately 55% of FHC patients are uninsured. In FY08 and FY09, FHC's charity care (sliding-fee discounts and bad debt) totaled $9.3 million and $11.1 million respectively."

RESPONSE: Park DuValle Community Health Center, Inc.

"The Indigent Care Grants were used to pay a small portion for the costs of delivering uncompensated primary care to uninsured patients. Our Uninsured Patient Population is approximately 65%. The amount of Fiscal Year 2009 and 2010 Sliding Fee Discounts and Bad Debts associated with serving this patient population was $3.9 million and $3.3 million respectively."

In the March 16, 2010 Partnership Council meeting, various members of The Partnership Council voiced concerns regarding lack of disclosure of the indigent care grants. Additionally, one member of the Council noted "that keeping the monies for indigent care in the Louisville area and not offering it to the other counties in the PHP region when they are facing the same issue was inappropriate." Per March 16, 2010 minutes:

"Various members of The Partnership Council voiced their concerns regarding the lack of earlier disclosure to the Council regarding the return of capital and the indigent care grant, noting it gives the illusion that UHC is "hiding" money and using reserves only in Jefferson County area. Mr. Gray commented there is a sense of lost trust with UHC and PHP amongst the hospitals, pharmacists, and physicians in the 15 outlying counties of Region 3. Ms. Sims of Lincoln Trail District Health Department noted the same is true for the departments of health outside Jefferson County. Dr. Hedrick noted that keeping the monies for indigent care in the Louisville area and not offering it to the other counties in the PHP region when they are facing the same issue was inappropriate."

Per the August 3, 2011 UHC Board meeting minutes, a Grant Committee will be a subcommittee of the Finance Committee. The Grant Committee will meet on an ad hoc basis and will report recommendations to the Board. The Board will make the final decision on all grant awards.

Comparison Survey Grants Questions

In response to the comparison survey questions B3.28 through B3.31, PHP provided additional detail regarding grant awards and distributions.

- (B3.28) Does the contract with the Medicaid agency include limitations or restrictions on health plan issued/awarded grants? Does the health plan issue/award grants? Please specify contract section and requirements for issuing/awarding grants.

- ***PHP Response to B3.28***: *"No - the Medicaid contract does not include limitations or restriction on health plan issues/awarded grants. Yes – PHP issues/award grants. Grants are awarded in accordance with the current PHP Grants policy (see attached)."*

- (B3.29) If the health plan has issued/awarded grants, what was their purpose? What type of entities have been issued/awarded grants? Please specify whether these entities are health care providers, subcontractors, vendors, or other entity, and whether there is any type of ownership or related party relationship to the health plan.

  PHP Response1 to B3.29: *"For the time period July 1, 2010 – June 30, 2011, Passport Health Plan paid out three main types of grants. The amounts paid and the detail for each grant is included.*

  - *Improved Health Outcome Program (iHOP) –this was originally established in 2007 and is now beginning its fifth cycle. An overview of the iHOP grant is included as well as a list of frequently asked questions.*

  - *Passport also gave an Asthma Control Grant during this time period. Details of this grant are attached.*

  - *The final grant for this time period was grants to the Health Departments in our region. This money was paid to subsidize the health departments for their care of Passport members and uninsured members. An allocation of funds is attached.*

  Passport has recently created a Grant Policy and a Grants Committee, which is a subcommittee of our Finance Committee of the Board. The newly created Grant Policy is attached."

  PHP Response2 to B3.29: "*The purpose of the Grants was to provide funding to health care providers, companies and organizations that have services and programs that directly and indirectly benefit Medicaid and Medicare eligible populations. Grants may also benefit low income and uninsured individuals*

within the service area. Passport has issued grants to health care providers and organizations that benefit low income, underinsured, uninsured, Medicaid and Medicare eligible populations.

The five sponsoring organizations represent the overwhelming majority of the medical safety net within Jefferson County and the Passport region, respectively. Four of these organizations provide substantially all of the graduate medical education for this region and about half of GME of the Commonwealth. Finally, the federally-qualified health centers and primary care centers comprising the Louisville Primary Care Association account for a very high percentage of the medical safety in the community. It is Passport's belief that supporting and developing the medical education and medical safety net in the region is an important mission of the plan and an appropriate use of funds that might result from cost savings achieved by the plan.

For purposes of this response, a grant is the transfer of money or property from a sponsor to an institution that may require performance of specific duties such as research, budget reports, progress reports, and return of unused funds. This is in contrast to a donation or sponsorship which is a restricted gift or contribution designated for a specific purpose, program or project. In conjunction with the Grant policy approved at the August 3, 2011 Board meeting, the UHC Board determined that any award or issuance to a health care provider, organization or company that exceeds $5,000 should be considered a Grant and be subject to the requirements of the UHC Grant policy."

- (B3.30) Total grant payments issued/awarded for twelve (12) month period.

  PHP Response 1 to B3.30: "*For the time period July 1, 2010 through June 30, 2011, University Health Care, Inc. paid out three grants. The amounts paid and the detail for each grant is included.*

  Improved Health outcome Program (iHOP) – This grant program was originally established in 2007 and is now beginning its fifth cycle. An overview of the iHOP grant is included as well as a list of frequently asked questions.

  Asthma Control – The documentation included indicated that the grant was to cover the cost of the mailing of a survey associated with an assessment of asthma control.

  Health Departments located in Region 3 – This grant was awarded to subsidize the health departments for their care of low income, underinsured, uninsured, Medicaid and Medicare eligible populations. An allocation of funds is attached."

  PHP Response 2 to B3.30: *$723,356.*

- (B3.31) Who within the health plan issues/awards grants? What is the Medicaid agency's role (if any) to authorize grants? What are the responsibilities or obligations of the receiving entity?

  PHP Response 1 to B3.31: *"For the time period July 1, 2010 – June 30, 2011, Passport Health Plan paid out three main types of grants. The amounts paid and the detail for each grant is included.*

  - *Improved Health Outcome Program (iHOP) – this was originally established in 2007 and is now beginning its fifth cycle. An overview of the iHOP grant is included as well as a list of frequently asked questions.*

  - *Passport also gave an Asthma Control Grant during this time period. Details of this grant are attached.* See related response in section above.

  - *The final grant for this time period was grants to the Health Departments in our region. This money was paid to subsidize the health departments for their care of Passport members and uninsured members. An allocation of funds is attached.*

  Passport has recently created a Grant Policy and a Grants Committee, which is a subcommittee of our Finance Committee of the Board. The newly created Grant Policy is attached."

  PHP Response 2 to B3.31: *"The University Health Care, Inc. (UHC) Board of Directors issued/awarded Grants during the timeframe from July 1, 2008 to current. The UHC Board of Directors continues to issue/award Grants. At the August 3, 2011 board meeting, which is after the aforementioned timeframe, the UHC Board of Directors approved its current Grants Policy (see explanation below). The Department of Medicaid Services does not have a role with regard to the authorization of the Grants issued/awarded by UHC. The responsibilities or obligations of the receiving entity are as explained below.*

  Prior to August 3, 2011, the Board of Directors made Grants in two distinct forms. First, the Board established the Integrated Health Outcomes Program (iHOP). The iHOP program provided up to five $50,000 grants annually for innovative programs that would impact outcomes in a variety of manners. An example would be the Kangaroo Care program, which encourages breast feeding newborns. The Kangaroo Care program has been replicated in other areas. iHOP is administered under a contract between UHC and the University of Louisville School of Medicine. iHOP solicited applications, evaluated and awarded the grants and monitored results. The Board would also from time to

time make grants on an ad hoc basis. These grants were evaluated at the Board level.

In accordance with the UHC Grant policy, effective August 3, 2011, Grants are recommended for Board approval by the Grants Committee. IHOP continues to be administered through the University; however, such grants are also approved and recommended by the Grants Committee, then are evaluated by the Finance Committee and ultimately approved by the Board. The Department of Medicaid Services does not have a role with regard to the authorization [of] Grants. The policy and procedure for Grants is contained in the Passport Health Plan Grant policy. Specifically, we require an entity that would like to receive a Grant to submit an application. The Grant Committee, which is a subcommittee of the Board Finance Committee, reviews the applications and makes recommendations to the full Board. The Board makes the final decision on the award of Grants. After the award of the Grant, the awardee is required to provide periodic reports on the use of the funds and the awardee is required to return any unused funds.

For purposes of this response, a grant is the transfer of money or property from a sponsor to an institution that may require performance of specific duties such as research, budget reports, progress reports, and return of unused funds. This is in contrast to a donation or sponsorship which is a restricted gift or contribution designated for a specific purpose, program or project.

In conjunction with the Grant policy approved at the August 3, 2011 Board meeting, the UHC Board determined that any award or issuance to a health care provider, organization or company that exceeds $5,000 should be considered a Grant and be subject to the requirements of the UHC Grant policy."

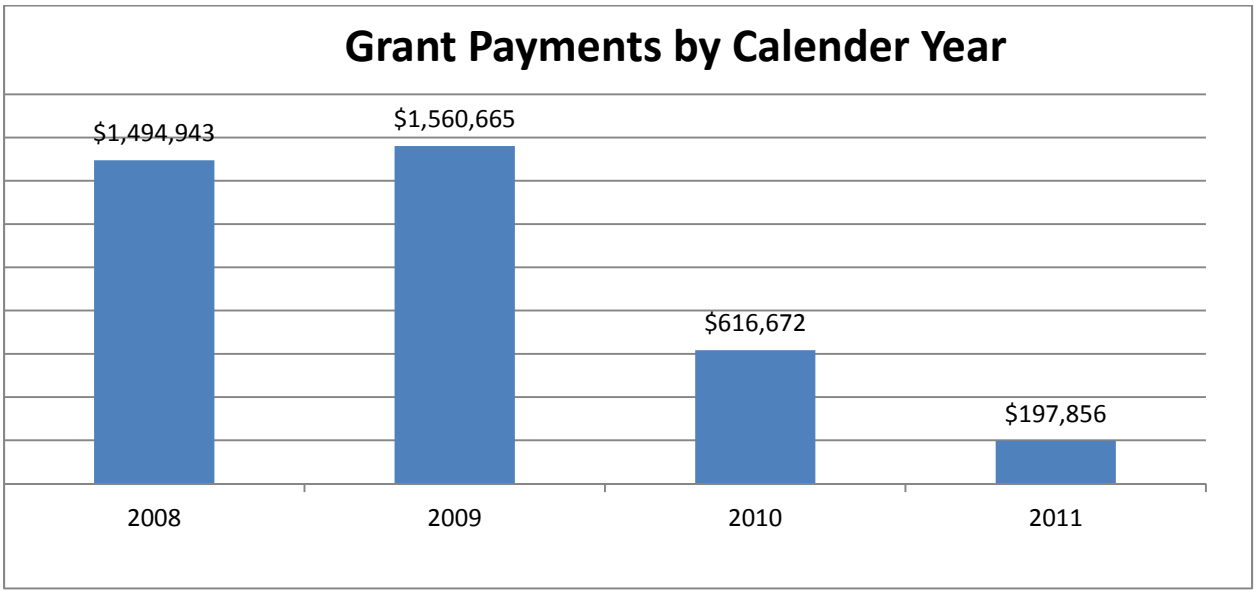
In response to our other requests for information, PHP submitted numerous files to support the Grant awards and distributions to providers. However, there was insufficient information available to permit us to confirm that the appropriate oversight, transparency, and authority was applied to the approved grants. In some cases, we noted that a grant payment was made and there was no corresponding approval in the Board meeting minutes. We were unable to confirm the grant amount calculations based on the documentation PHP submitted.

Grant Expenditures

Based on the data submitted by PHP, total grant expenditures were approximately $3.8M during the engagement window[36]. By year, these amounts are $1,494,943 (39 percent), $1,560,665 (40 percent), $616,672 (16 percent), and $197,856 (5 percent) for

[36] These amounts exclude the Indigent Care Grants, which will be returned to UHC.

calendar years 2008, 2009, 2010, and 2011, respectively. The grant funds for 2011 are through June.



In the table below we illustrate grant expenditures by year, based on the expenditure detail submitted by PHP.

GRANT BY RECIPIENT BY CALENDAR YEAR

Grant Recipient	2008	2009	2010	2011	Total
Louisville Department of Public Health	$471,750	$518,930	$315,877	$0	$1,306,557
Lincoln Trail District	$309,000	$348,809	$104,234	$0	$762,043
Volunteers of America of KY	$250,000	$250,000	$0	$0	$500,000
UofL Research Foundation	$149,993	$99,665	$50,172	$148,614	$448,443
North Central District Health	$88,750	$96,954	$30,701	$0	$216,405
Bullitt County Health Department	$67,000	$34,816	$23,329	$0	$125,145
Breckinridge County Health Center	$33,250	$16,395	$10,406	$0	$60,051
Bridgehaven, Inc.	$0	$50,000	$0	$0	$50,000
University of Louisville Hospital	$0	$25,000	$25,000	$0	$50,000
Jewish Hospital Foundation	$0	$0	$0	$49,242	$49,242
Three Rivers District	$17,500	$21,512	$6,783	$0	$45,795
Bardstown Primary Care	$20,000	$20,000	$0	$0	$40,000
Oldham County Health	$12,750	$12,584	$8,670	$0	$34,004
Bellarmine University	$0	$16,000	$16,000	$0	$32,000
Center for Courageous Kids	$0	$25,000	$0	$0	$25,000
Health Kentucky Incorporated	$0	$25,000	$0	$0	$25,000
Louisville Metro Public Health	$0	$0	$25,000	$0	$25,000

Grant Recipient	2008	2009	2010	2011	Total
Louisville/Jefferson County	$25,000	$0	$0	$0	$25,000
University Medical Center	$25,000	$0	$0	$0	$25,000
Family Health Centers	$24,951	$0	$0	$0	$24,951
Kentucky African Americans	$0	$0	$500	$0	$500
TOTAL	**$1,494,943**	**$1,560,665**	**$616,672**	**$197,856**	**$3,870,136**

By awardee, grant payments have been made to 21 different entities. The largest grants have been awarded to, Louisville Department of Public Health, Lincoln Trail District, Volunteers of America of KY, Inc., and UofL Research Foundation. In the table below we have summarized the grants received, by recipient:

Grant Recipient	Health Department Grant	iHOP Grants	Grace House Grants	Asthma Control Grants	Camp Courageous	Bridge-Haven	Total
Bardstown Primary Care	$0	$40,000	$0	$0		$0	$40,000
Bellarmine University	$0	$32,000	$0	$0		$0	$32,000
Breckinridge County HC	$60,051	$0	$0	$0		$0	$60,051
Bridgehaven, Inc.	$0	$0	$0	$0		$50,000	$50,000
Bullitt County HD	$125,145	$0	$0	$0		$0	$125,145
Center for Courageous Kids	$0	$0	$0	$0	$25,000	$0	$25,000
Family Health Centers	$0	$24,951	$0	$0		$0	$24,951
Health Kentucky Inc.	$0	$25,000	$0	$0		$0	$25,000
Jewish Hosp Found	$0	$49,242	$0	$0		$0	$49,242
Kentucky African Americans	$0	$0	$0	$500		$0	$500
Lincoln Trail District	$762,043	$0	$0	$0		$0	$762,043
Louisville DPH	$1,256,557	$50,000	$0	$0		$0	$1,306,557
Louisville Metro Public Health	$0	$25,000	$0	$0		$0	$25,000
Louisville/Jefferson County	$0	$25,000	$0	$0		$0	$25,000
North Central District Health	$216,405	$0	$0	$0		$0	$216,405
Oldham County Health	$34,004	$0	$0	$0		$0	$34,004
Three Rivers District	$45,795	$0	$0	$0		$0	$45,795
UofL Research Foundation	$0	$447,943	$0	$500		$0	$448,443
University Medical Center	$0	$25,000	$0	$0		$0	$25,000
University of Louisville Hosp	$0	$50,000	$0	$0		$0	$50,000
Volunteers of America of KY	$0	$0	$500,000	$0		$0	$500,000
TOTAL	**$2,500,000**	**$794,136**	**$500,000**	**$1,000**	**$25,000**	**$50,000**	**$3,870,136**

According to the payment files received from PHP, disbursements were made to six different types of grants during our review period. The majority of the payments were paid for three grants: Health Department Grants $2,500,000 (65 percent); iHOP Grants $794,136 (21 percent); and Grace House Grants $500,000 (13 percent).
In the table below we have summarized grant type by year:

Grant Type	2008	2009	2010	2011	Total
Health Department Grants	$1,000,000	$1,000,000	$500,000	$0	$2,500,000
iHOP Grants	$244,943	$235,665	$115,672	$197,856	$794,136
Grace House Grant	$250,000	$250,000	$0	$0	$500,000
Camp Courageous	$0	$25,000	$0	$0	$25,000
Bridgehaven	$0	$50,000	$0	$0	$50,000
Asthma Control Grant	$0	$0	$1,000	$0	$1,000
TOTAL	**$1,494,943**	**$1,560,665**	**$616,672**	**$197,856**	**$3,870,136**

During our interview with PHP personnel in January 2012, we learned that there were three discretionary grants during the audit window (Grace House, Camp Courageous and Bridgehaven). These three grants are sometimes also referred to as "sponsorships".

Health Department Grants

There were seven payees for Health Department Grants as follows: Breckinridge County Health Department; Bullitt County Health Department; Lincoln Trail District; Louisville Department of Health; North Central District Health; Oldham County Health Department; and Three Rivers District. Following is a summary of the information provided by PHP personnel during the interview:

- PHP represented that the grants are sometimes made for a specific purpose and other times not.
- They also stated that the grants are allocated based on county population/membership and that the grants are distributed in $500,000 increments in one or two distributions at the Board's discretion based upon net income.
- The funds are "unrestricted" based upon where PHP was at a point in time which was usually at the end of the year. The grants were driven by the Health Department needs.

Improved Health Outcomes Program (iHOP)

During our interview of PHP personnel, we obtained information about the iHOP program and have summarized the information below:

- iHOP has a contract with Dr. Mark Pfieffer (UofL Medical School) to administer the program with awards of $250,000 annually.
- There is a committee (Dr. Pfeiffer and five to six other individuals) that makes the decisions and Dr. Simmons also participates.
- There are typically five grants awarded at $50,000 each.
- The grant must be for a specific purpose of improving outcomes.
- At the end of the cycle a report is issued and if outcomes were not attained, the funds would need to be returned.
- Dr. Pfeiffer made sure to have at least one rural facility and the bidding was open to community agencies, all provider types and categories.
- The process starts with a letter of intent (mini proposal). Proposals are screened and the applicants are notified of both approval and non-approval.
- Dr. Pfeiffer has been on the board previously. He was reimbursed from the UofL Research Foundation at an hourly rate with an annual maximum.
- PHP personnel stated that they believed there to be no requirement to communicate iHOP information to DMS.
- iHOP costs are considered administrative costs of PHP and included in the capitation rate ranges.
- Check requests were sent to UHC indicating how much to pay per recipient. The second installment request would indicate whether they qualified for the second installment.

Payments made to the iHOP program recipients are detailed above in the table "Grant Type by Recipient". We requested that Passport provide us with a detailed description of the iHOP Grant process from Dr. Pfeifer, including how grant applications were solicited, evaluated, and approved, including whether they were competitive or non competitive in nature. We also requested that they indicate what post grant activities are performed to ensure that funds were appropriately used, and that grant activities were consistent with the application. Passport submitted the following response:

> *The iHOP processes are described in detail at the iHOP website www.passporthealthplan.com/provider/ihop. This public website includes the goals of the program, the application processes, and timelines for each cycle, sample applications and budgets, and previously funded projects. The FAQ section is particularly important as it responds to specific questions from the public about the program.*

Besides the website, applications are solicited via written and electronic communications, including but not limited to provider newsletters and email listservs. Previous applicants, successful and unsuccessful, and major health care organizations in the region are also contacted about each cycle. In addition, the Partnership Council and Board have received periodic in person updates and application requests from Dr. Pfeifer. Many interested applicants contact Passport directly and are referred to the website and the iHOP office staff. The goal is to solicit the largest number of applications from the broadest geographic area in Passport's region. There has been a particular emphasis to encourage non-Jefferson County projects.

The iHOP program is very competitive with approximately 35-50 Letters of Intent per cycle and only 5 awards. The Review Panel judges the proposals per iHOP guidelines and goals.

The iHOP office manages the program from first inquiry to final report. Following a notification of award, the office arranges funding of the first half of the award. A six month progress report is required, with appropriate progress made, before the second fund transfer is made. A final report is due after the award period to assure the project was completed as designed and to distribute the results. In two cases funds have been returned to Passport due to the inability of the awardees to carry out the project as designed.

…

The board of University Health Care (UHC), the company operating as Passport Health Plan, has set aside funds for research and development of programs that would improve the quality, access, efficiency, and cost of health care delivered to their constituents. The iHOP initiative will seek proposals from entities that provide services directly or indirectly to Medicaid or uninsured patients in Region 3 - the 16 counties in the Louisville region. Funding is for one time projects that could be completed in 1 year with quantifiable outcomes.

The Goals of the iHOP

iHOP projects should seek to advance the health care of the Medicaid and uninsured population in Region 3 though initiatives that:

1. *Lead to a better understanding of the needs, access issues, and quality of care in this population*

2. *Design and test models or programs to improve the quality of care in this population*
3. *Design and test models or programs to improve the satisfaction with care in this population*
4. *Design and test models or programs to improve the access to care in this population*
5. *Design and test models or programs to improve the cost effectiveness and efficiencies of providing care to this population*
6. *Explore and test unique collaborations or partnerships that offer opportunities to improve the care for this population including community-based initiatives*
7. *Design and test care management programs*
8. *Design and test programs to address health care disparities"*

Asthma Care Grant

During our interview, we were informed that the Asthma Care Grant was a one-time grant of $500. We were able to verify a payment to the Kentucky African Americans Organization in that amount. However, we also noted what appears to have been a second payment of $500 to the University of Louisville Research Foundation for this grant. We did not receive any additional information regarding this grant and due to the immateriality of the payments, we passed on further inquiries.

Other Discretionary Grants

During the course of our interview with PHP, we learned of other grants that were distributed during the engagement window. These grants are sometimes referred to as "sponsorships". We inquired about the process of requesting and receiving these grants and were given the following responses:

- The organization's Board would approach management and make a presentation on how they may benefit from issuing the proposed grant.
- The recommendations would first go to the finance committee, then the full Board for a vote.
- They did not believe it was necessary to obtain DMS approval and DMS was not at the Board meetings.
- There was mandatory reporting to DMS on a quarterly basis and the information was used for the CMS waiver, but not necessarily included in the reports.
- All grants were openly discussed at the Board meetings and otherwise not reported to DMS. Grant information was included in administration costs used in the rate setting data.

A new grant policy was implemented by UHC in August 2011. There have been no grants issued since that time. The new policy will require monitoring by UHC and follow-up from the recipient. There is one grant application in process (to keep kids asthma under control) for $10,000."

Grace House (Board Approved 10/14/2009)

Grace House is a substance abuse center for pregnant women and counseling center. It was represented that "many of their members are Passport members". Payments of $250,000 each in 2008 and 2009 were made to the payee of Volunteers of America of KY, Inc.

Camp Courageous (Board Approved 10/14/2009)

Camp Courageous is for children with severe medical issues and medically fragile children. The camp offers an opportunity for children to attend camp and still receive their treatments. The camp received a one-time payment of $25,000 in 2009. The camp is located in Central Kentucky and Dr. Rabelais, who served as a member of the UHC board during the engagement period, visits the camp upon occasion. PHP confirmed that Dr. Rabalais does not have a financial interest in Camp Courageous.

Bridgehaven (Board Approved 10/14/2009)

Bridgehaven is a day program for individuals with behavior health issues and provides lunches and dinners to handicapped individuals. The program also deals with coping skills and schizophrenia. Bridgehaven received a one-time payment of $50,000 in 2009.

Other discretionary grants

We were informed that that there are other programs not included in the data file as follows:

1) Heuser Clinic "lifestyle benefit"-approximately $50,000 per year
2) Smoking Cessation Program - approximately $200,000 appropriated per year (not a grant).

√ Observations, Findings or Recommendations Related to the Grant Award Process

1) Grant payments made by PHP during the engagement window are not described in the contract between the Department and UHC. Details regarding grant programs should be submitted to the Department and documented within the contract between the Department and UHC.

2) Grants other than the iHOP appear to have been made with insufficient oversight and with varying degrees of guidance. All grants that have been authorized by the Department should be addressed by a comprehensive grants policy and procedure. The policy and procedure should include requisite information such as the application process, eligibility criteria, goals and objectives, terms of use, award and payment processes, reporting, and post grant procedures to confirm that the funds have been properly used as authorized. The grants policy should also include the evaluation and award process, and board oversight responsibilities. The contract between the Department and UHC should describe how grant payments should be reported by the health plan, and how grants should be treated for purposes of reporting health plan medical and administrative expenses. A comprehensive list of grants should be maintained and made available to the public. The grant policy adopted in July 2011 should be reviewed to confirm that it meets or exceeds these requirements.

3) Grants paid by UHC are not required by the contract between the Department and UHC. As such, these payments are considered "discretionary", which appear to have been made without the authorization of the Department. Therefore, we recommend that Passport seek guidance from the Department on the appropriate classification (i.e., medical or administrative) of the payments, and to request guidance regarding their permissibility. [37]

[37] While we consider these grants discretionary in nature, we do not intend to imply that the grants were not beneficial to the Medicaid population. PHP indicated that the forensic medicine grant, in particular, has been successful throughout the Commonwealth.

Objective 5A-B: Utilization Practices

Key objectives of this analysis:

To review Passport and AmeriHealth Mercy Health Care Utilization practices:

e) Review utilization trends

f) Review utilization patterns to determine whether there has occurred, or whether opportunity exists, for Passport to engage in population manipulation that might tend to maximize profit.

Database Development

As part of this objective, we requested data from the Department's Fiscal Agent Contractor (FAC), Hewlett Packard Enterprise Services (HP). We requested Passport encounter claims, fee-for-service (FFS) claims, and Pharmacy claims for State Fiscal Years (SFY) 2007-2011, which includes dates from July 1, 2006 through June 30, 2011. The data received includes claims that were paid, and paid claims that may have had denied detail lines. Claims rejected or claims denied at the header level were not included.

Certain characteristics, within the data, limited the analysis of information. For example, the data did not include a reason code for member disenrollment changes. Additionally, while the date the claim was received is recorded in the Internal Control Number (ICN) on the fee for service claims, the date the claims were received is not included on the managed care encounter claims. Lastly, the encounter claim volume for 2011 is likely understated due to claims completion/timing issues.

Utilization Analysis

Myers and Stauffer conducted an analysis of utilization trends, with the primary focus on the population enrolled in Passport, the severity level of their conditions, and their medical needs. We analyzed characteristics such as average age, the complexity of conditions, emergency room utilization, inpatient average length of stay, explanation of benefit, and claim timeliness.

In addition, we performed an analysis to identify the volume of members that have entered and exited the Passport program, reviewing the historical net change.

Member Enrollment

On September 2, 2011, we requested from PHP policies and procedures pertaining to member assignments. Information requested was not available and/or not submitted from Passport. AMHP submitted Policy and Procedures for Member Enrollment (effective 7/18/2011). We have outlined these processes below:

***"POLICY**:*

To accurately enroll into the Healthcare System any Medicaid recipient who is assigned to the Company in accordance with all Federal HIPAA privacy regulations…All documentation created or maintained in this policy will be recorded in the appropriate information system. The Company shall retain documents relating to Protected Health Information for seven years in accordance with company policy…

***PURPOSE**:*

To establish written guidelines for new member enrollment.

***PROCEDURE**:*

I. *The Enrollment Process is initiated by the State of Kentucky. The IS Department receives an electronic file from the Kentucky Department for Medicaid Services (DMS) daily, and loads this file into the Healthcare system. In addition we receive two reconciliation files per month, one between the first and the fifth of the month, and the second on the Tuesday before the last Thursday of the month. No daily file is sent the day after the reconciliation file is received.*

II. *The IS Department electronically enrolls/disenrolls or updates members according to the information on the State file.*

III. *The reports are extracted by the Enrollment Representative and distributed to the Enrollment staff and run on a daily basis.*

IV. *Daily error reports are reconciled daily, prior to the run of the next eligibility file. The reports are kept on hand for 18 months, and then destroyed.*

V. *Each day, the Enrollment Representative will investigate the Kentucky State system and reconcile the discrepancies on the Heatlhcare system, by the monthly billing deadline.*

VI. *The Monthly File is sent the Thursday before the last Friday of each month. This file includes: all members on file for the month; disenrolled members; updates not previously sent on the daily file.*

VII. After these reports are completed, the work is given to the Enrollment Representative to be filed."

We also obtained the AMHP's Newborn Enrollment Policy and Procedures (effective 6/1/2010) and found it to have similar language as the Member Enrollment Policy and Procedures. Both policies appear to be updated and/or reviewed on an annual basis.

Myers and Stauffer conducted a telephone interview with the Director of Member Services at DMS. The purpose of the interview was to assess the risk of patient/member manipulation. Salient portions of the interview are summarized below:

> *The Director stated it would be unlikely for patient manipulation to occur. The members get assigned to Passport through the eligibility system. She stated a patient may be recommended for a waiver, which would cause the member to be disenrolled from Passport. The Director explained that there are two waivers: Home and Community Based Services (HCBS); and Michelle P for Autistic Children. She explained that waiver services have to be prior authorized by DMS as check and balance.*
>
> *The Director stated that eligibility is determined in the county offices and partnership arrangements, through coalitions at schools and within communities. She stated there are nightly feeds of the eligibility system to HP.*

Although requested from PHP and AMHP, we did not receive a policy on member termination. A policy would list proper causes and the procedures for which a member may be disenrolled.

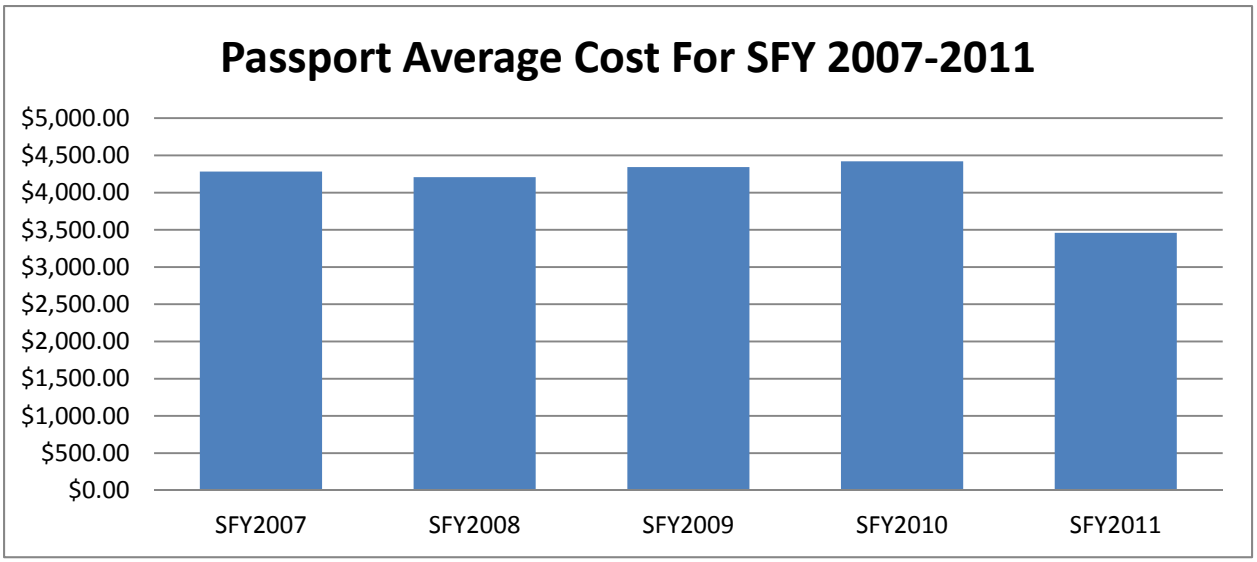
Member Utilization

Myers and Stauffer analyzed Passport encounter data showing the number of encounters and total dollars spent on these services for SFY 2007-2011. Encounter data for the purposes of this report, is defined as all data captured during the course of a single health care encounter that specifies the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the member receiving services. We made certain adjustments to members and services between the FFS and Passport programs to permit direct comparison of information.

Costs per Member

The goal of managed care is to provide high quality care while controlling costs. We analyzed Passport data, illustrating the average costs per member for services for SFYs 2007 through 2011. An encounter, for the purposes of this report, is defined as the number service claims in a given state fiscal year. The purpose of this analysis is to show the average costs per Passport member during each fiscal year for the examination period.

Chart 5-1



Of the five SFYs evaluated for Passport, SFY2010 had a slightly higher average cost per year at $4,421. SFY2011 had the lowest average cost at $3,459 based on the encounter data provided.

For Passport members, the average dollars spent per member in any given fiscal year for this reporting period was $4,143. According to the *CMS Actuarial Medicaid Report 2010*, the national per enrollee expenditure in Federal FY2009 for children was $2,848 and for adults the average was $4,123.[38] For Passport in SFY2009 the average cost per member was $4,344 which includes both children and adults. The national average per enrollee expenditure when combining those groups together was $3,486.

Emergency Room Claims

To measure emergency room (ER) utilization, we developed an analysis to report the ER claims by quarter and the level of care provided. The level of care is defined by the Current Procedure Terminology (CPT) code billed with a '450' revenue code on a UB04 claim form. CPT codes include the following: 99281, 99282, 99283, 99284, 99285, 99291, and 99292. The CPT codes are evaluation and management codes that increase in medical complexity from 99281 through 99292. We compared the number of emergency room claims by the level of care provided for Passport to the FFS population claims experience using the same level of care CPT codes. The use of the lower level of care codes (99281 and 99282) is trending downwards and use of the

[38] The CMS report includes Total Title XIX outlays, excluding costs in support of the Children's Health Insurance Program. This includes expenditures made by the State to health plans and providers. These amounts are shown for relative comparison only and may not utilize identical factors in determining average costs.

higher levels of care is increasing. Codes 99291 and 99292 are critical care codes and do not experience the level of usage comparable to 99281 through 99285.

For reference, the CPTs and descriptions used in the analysis are as follows[39]:

- 99281 – Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor.

- 99282 – Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity.

- 99283 – Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate severity.

- 99284 – Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

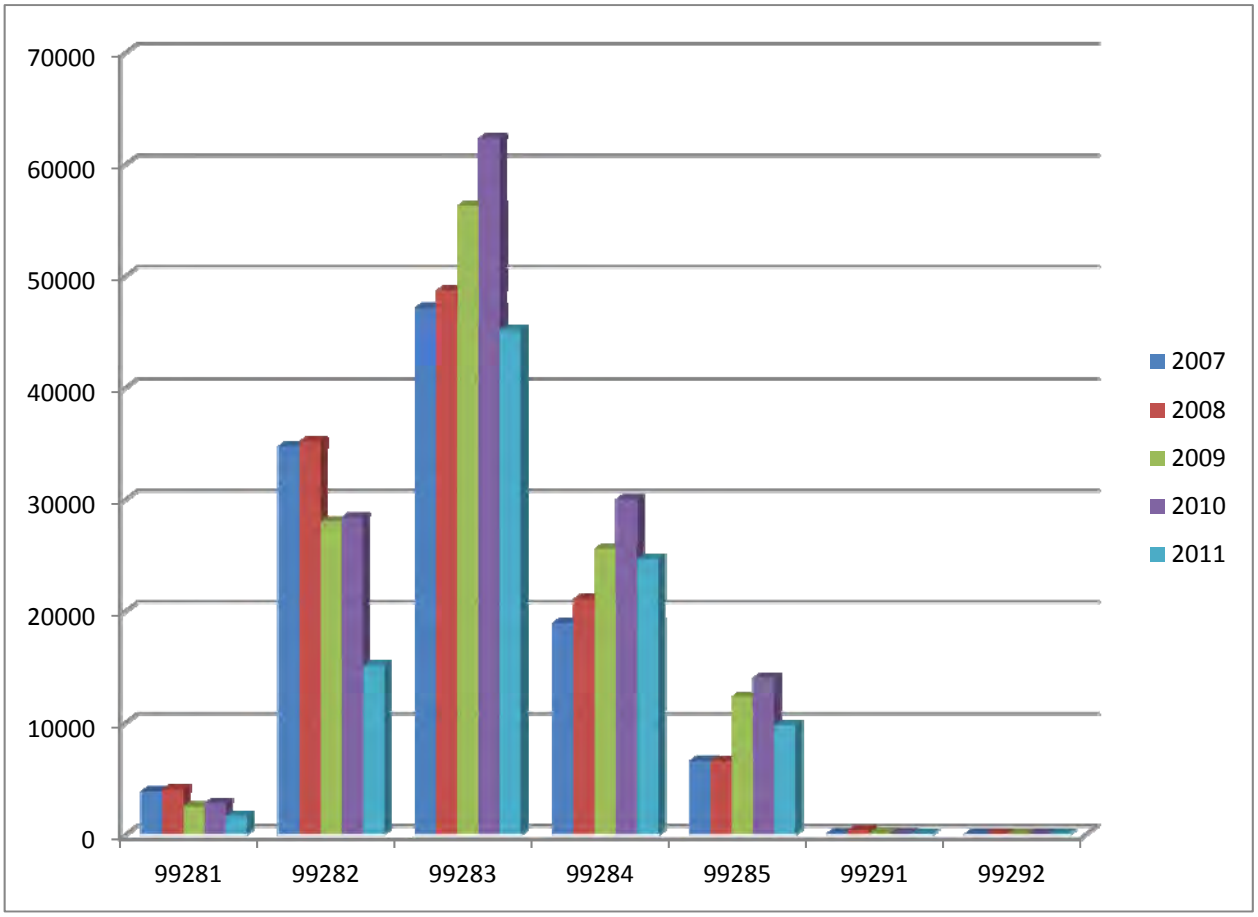
- 99285 – Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

- 99291 – Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

- 99292 – Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

[39] Source: Ingenix "EncoderPro," subscription licensed to Myers and Stauffer LC

Chart 5-2: Passport ER claims by SFY and level of care



Explanation of Benefit (EOB) Codes

EOB codes are assigned to claims to describe to the provider how the claim was adjudicated. EOB codes may also be referred to as Explanation of Payment (EOP) codes. For this analysis, the EOB that was sent to the provider by Passport is not available in the encounter claims. However, EOB codes assigned by the HP MMIS when the encounter claims are loaded are available. The tables below provide the descriptions and frequencies of the top ten EOB codes in the encounter data by SFY. *Please note that the EOB codes do not directly correspond to a "denied" claim.*

EOB Codes and Descriptions

EOB Code	Description
409	Invalid provider type billed on claim form.
482	Claim/detail denied. Duplicate service billed.
754	Early refill.

EOB Code	Description
984	Medicare EOMB does not indicate that coinsurance and deductible amounts are due.
1058	No pay to provider record for crossover claim.
1862	Billing provider taxonomy code mismatch for claim data of service.
1955	Claim/service denied. The billing provider national provider identifier (NPI) submitted on the claim cannot be…
3999	Claim billed with inactive member ID number.
283	Our records indicate member has Medicare Part B, please bill Medicare.
1870	Billing provider submitted NPI and Legacy number. Legacy number not processed.

Top Ten Encounter EOB Codes, by SFY

EOB Code	SFY 2007		SFY 2008		SFY 2009		SFY 2010		SFY 2011		Total	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
409	15,424	0.88%	112,006	3.46%	317,501	13.70%	249,508	15.01%	235,211	14.74%	929,650	8.80%
482	264,723	15.11%	198,612	6.14%	188,872	8.15%	173,373	10.43%	142,733	8.95%	968,313	9.17%
754	1,265,793	72.26%	-	0.00%	-	0.00%	-	0.00%	-	0.00%	1,265,793	11.98%
984	82,048	4.68%	439,819	13.60%	170,086	7.34%	63,818	3.84%	47,283	2.96%	803,054	7.60%
1058	4,722	0.27%	709,178	21.93%	2,267	0.10%	6	0.00%	3	0.00%	716,176	6.78%
1862	-	0.00%	30,952	0.96%	273,032	11.78%	223,415	13.44%	193,858	12.15%	721,257	6.83%
1955	780	0.04%	124,459	3.85%	233,934	10.09%	166,953	10.04%	211,775	13.27%	737,901	6.99%
3999	5,341	0.30%	1,490,230	46.07%	680,362	29.35%	430,764	25.92%	404,285	25.34%	3,010,982	28.51%
283	112,909	6.45%	115,883	3.58%	160,377	6.92%	145,841	8.77%	156,205	9.79%	691,215	6.54%
1870	-	0.00%	13,256	0.41%	291,415	12.57%	208,431	12.54%	204,278	12.80%	717,380	6.79%
Total	**1,751,740**	**100.00%**	**3,234,395**	**100.00%**	**2,317,846**	**132.32%**	**1,662,109**	**100.00%**	**1,595,631**	**100.00%**	**10,561,721**	**100.00%**

Passport may want to assess the frequency of the EOB codes and determine whether opportunities for provider education exist when the EOB code is appearing on the encounters more frequently.

Member Change Trends

We analyzed the number of members who entered and exited Passport from 2005 through June 2011. In addition to tracking member changes, we also analyzed the average dollars spent on the members from the prior quarter, which could identify potential incentive for member manipulation. If the member is entering Passport from FFS, we analyzed the average dollars for those members in the quarter preceding Passport enrollment. We analyzed the opposite scenario when a member moved from Passport to FFS.

Column h in the table includes the "Net Change Cost Differential", which is computed by subtracting the average cost of members entering Passport from members exiting. The data suggests a trend where the cost of members exiting is greater than the cost of members entering. However, without the reason code and time for further analysis, we cannot draw any conclusions regarding the cause of this trend. As was stated during the interview with the Director of Member Services at DMS, we agree with the Director's assessment that there is a low risk that high cost members could be manipulated out of Passport. However, the data suggests that high cost members are exiting Passport, perhaps as a matter of policy. For example, members with behavioral health needs, members entering a waiver program, or members entering a nursing facility would likely constitute reasons for exiting Passport. The high costs of these patients are a likely indication of their health needs and justification for entry into a nursing facility or waiver program.

Table 5: Member Change Trends

Year and Quarter	Number of Members Exiting Passport	Previous Quarter's Passport Average Dollars Paid per Member	Static Membership in Quarter	Average Dollars per Static Member	Number of Members Entering Passport	Previous Quarter's FFS Average Dollars paid per member	Net Change Cost Differential
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h = g-c)
2006Q4	43,040	78.62	618,148	39.81	42,750	64.03	($14.59)
2007Q1	44,650	78.04	616,417	40.75	44,920	33.78	($44.26)
2007Q2	32,036	96.84	628,766	37.08	46,127	68.15	($28.69)
2007Q3	56,691	65.90	618,916	39.73	50,778	48.83	($17.08)
2007Q4	42,137	88.56	627,119	38.73	43,106	47.90	($40.65)
2008Q1	43,737	78.16	626,880	39.86	48,816	49.49	($28.68)
2008Q2	42,301	122.73	633,088	41.10	44,569	52.26	($70.47)
2008Q3	43,889	80.10	634,118	41.40	52,450	51.66	($28.44)
2008Q4	41,503	100.48	644,715	39.37	47,569	57.07	($43.40)
2009Q1	41,895	125.58	650,601	40.29	52,375	62.17	($63.41)
2009Q2	42,226	106.82	660,929	41.11	52,025	58.93	($47.89)
2009Q3	45,284	111.40	667,926	42.42	56,370	92.41	($18.98)
2009Q4	43,846	100.72	680,331	39.53	50,100	86.31	($14.42)
2010Q1	45,277	97.02	685,251	41.05	49,889	86.61	($10.42)
2010Q2	44,381	100.37	690,697	42.11	48,980	73.55	($26.82)
2010Q3	47,007	104.80	692,994	43.54	55,180	63.51	($41.30)
2010Q4	42,871	120.19	704,822	21.00	48,656	83.28	($36.91)
2011Q1	46,128	52.66	707,762	38.72	48,412	71.26	$18.60

Observations, Findings or Recommendations Related to Utilization Practices

1) A comprehensive member termination policy was not provided by PHP or AMHP. Although we received member policies from AMHP, they do not provide a sufficient level of detail. Member set up, change, and termination policies and procedures should include details about the member aid categories and other specific information in the process.

   As an example, please refer to excerpts (steps III, IV, and V) from AMHP's procedures document listed below. Step III does not include information about what reports are extracted and what happens to the reports after they are distributed to the member services staff. Step IV does not indicate what the error reports are reconciled to, what happens to errors found during reconciliation, and does not describe the rationale for destroying reports after 18 months, which appears to be inconsistent with the requirements of the Contract to maintain documentation for a "period of not less than three (3) years after all matters pertaining to this contract (e.g., audit, settlement of audit exceptions, disputes) are resolved…" Step V does not describe the process used to "investigate the Kentucky State System", nor does it identify the system being investigated. The procedure document does not include discussion related to the quality assessment procedures performed throughout the process to ensure that information is accurately presented.

   III. "The reports are extracted by the Enrollment Representative and distributed to the Enrollment staff and run on a daily basis."

   IV. "Daily error reports are reconciled daily, prior to the run of the next eligibility file. The reports are kept on hand for 18 months, and then destroyed."

   V. "Each day, the Enrollment Representative will investigate the Kentucky State system and reconcile the discrepancies on the Heatlhcare system, by the monthly billing deadline."

2) The average costs per member for Passport appears to be comparable to the national average for total Medicaid expenditures per member.

3) For the Passport population, the use of the lower level of care codes (99281 and 99282) is trending downwards and use of the higher levels of care is increasing. This trend should be carefully monitored to ensure that ER costs are properly maintained.

4) There appears to be a trend of members with higher costs exiting Passport. However, the cause of the trend is inconclusive. We recommend that Passport continue to analyze the cause of the member changes and report findings to DMS.

5) Passport should continue to assess and analyze encounter and utilization data to ensure it is representative of the population, and that it includes the data elements required for proper monitoring and management of its enrollees. Data fields such as EOB codes for service denials and reason codes for membership changes are critical in understanding emerging trends and appropriately managing the Passport membership.

SUMMARY OF FINDINGS AND OBSERVATIONS

Objective #	Objective	Page #	Observations, Findings or Recommendations
1A	Passport Business Plans	28	1) The absence of a formal business plan during the audit window left the health plan vulnerable to be operated as the management in place deemed appropriate. Health plan administration and operations were not adequately documented during the audit window. During that period, there were few, if any policies and procedures in place specific to Passport Health Plan that would have guided and provided boundaries and limitations necessary for the appropriate management of the plan. PHP has indicated that they intend to address the lack of a formal business plan in the future. Additionally, the health plan has developed administrative and operational policies and procedures, subsequent to the audit window. 2) During the audit window, there were no specific provisions described in the contract between DMS and UHC for UHC to submit a comprehensive business plan. There were no specific requirements that UHC request DMS' authorization or approval of changes to the business plan. DMS addressed this observation by establishing requirements for the 2012 contract. 3) By placing AMHP employees in high level positions of authority, including Executive Director of Passport Health Plan and Chief Financial Officer of Passport Health Plan, there was insufficient monitoring of the TPA and other benefit subcontractors during the period covered by the audit. Because certain subcontractors of PHP are related parties of AMHP, there was significant risk of conflicts of interest or independence of those individuals (i.e., AMHP employees) who performed those functions prior to July 1, 2011. 4) During discussions with Passport employees who were AMHP employees prior to July 1, 2011, it was apparent that there was a significant amount of confusion regarding the roles and responsibilities related to the oversight of Passport's daily operations. 5) During the course of conducting interviews, we were informed that, during the period of our examination, a significant amount of uncertainty was present in the relationship between UHC/PHP and AMHP. This may have been as a result of discussions related to proposed rate reductions to the AMHP contract and/or modification to the methodology for calculating incentives paid to AMHP for cost savings initiatives.

Objective #	Objective	Page #	Observations, Findings or Recommendations
			6) In spite of contract provisions requiring that the Board of Directors have control over all policies and assets of Passport, interviews with former UHC staff revealed that they did not have direct access to the financial systems or to the bank accounts for the health plan during the period of the examination. PHP informed us that the new TPA agreement with AMHP contains service level agreements which include certain performance standards, appropriate oversight of TPA functions, and that assets of Passport are under the exclusive authority of UHC.
1B	Comparison of Health Plan Operations and Best Practices	39	1) Internal Auditing does not appear to be listed in the functional area documentation submitted by Passport. Fraud, waste, and abuse activities are listed as an AmeriHealth Mercy's responsibility. PHP indicated they are now performing internal auditing and have hired a Director of Internal Audit. 2) The survey requests information regarding any health care service providers which may be owned by or affiliated with the owners of the health plan. Passport indicated their response to be No; however, a review of additional information provided by Passport provides an indication that several of the health plan sponsors are also health care providers. 3) There were conflicting responses given in section two of the survey regarding responsibility of functional areas. PHP has attempted to clarify these conflicts when possible. 4) Passport indicated that they do not subcontract with or use vendors who are subsidiaries or corporate related entities. It appears that this response may be inaccurate or Passport may have misunderstood the question. 5) Passport reported low utilization rates for emergency department visits per 1,000 members. PHP clarified that their response was indicative of the HEDIS measure.
1C	Revenue, Compensation and Expenditures	59	1) Interviews with Passport indicated there currently are no formal quality assurance processes related to financial management or reporting. Passport should develop and document such quality assurance processes. 2) We were unable to confirm the reasonableness of any methodology used to allocate shared administrative expenses between the Medicaid and the Medicare lines of business. Passport should document this process in order to ensure that future staff have a clear understanding of the allocation process and can demonstrate compliance. 3) During the period being analyzed, Passport reported paying approximately $227,000 in corporate and individual memberships. The largest portion, over $200,000, was related to national and state associations which Passport stated provided "industry information including legislation that affects Medicaid health plans". Passport should consider a policy that would require that the benefits of these memberships be demonstrated.

Objective #	Objective	Page #	Observations, Findings or Recommendations
			4) During the audit period, we noted sponsorships to entities that may not have provided a benefit to Passport Medicaid members. It appears that Passport is working to develop a more fiscally-responsible mind-set when the decision to make sponsorships is undertaken to ensure sponsorships are for the benefit of the health plan's members and has implemented a sponsorship and grants policy. 5) PHP indicated that it has implemented an executive compensation committee and engaged an outside consultant to ensure that it is able to adequately demonstrate that executive compensation has been thoroughly evaluated and is comparable to similar positions within the industry. 6) It was noted that certain former Passport employees received severance packages which could be considered generous. While Passport indicated that these severance agreements were arrived at based on sound legal advice, we recommend that Passport develop policies regarding severance packages including, which staff is eligible, under what circumstances will severance be paid and a reasonable basis for calculating the severance amount that is paid. 7) Because of the lack of certain written contracts for subcontractors, Passport may be in violation of 42 CFR 434.6 which requires that all subcontracts be in writing and for the subcontracts themselves to also meet the requirements of federal contracting laws. PHP provided commentary that disputed the consulting analysis from Krieg DeVault. DMS may wish to consult the Department's legal counsel on this matter.
1D	Provider and Member Complaints and Concerns Regarding Passport Health Plan	69	1) It appears that provider satisfaction is relatively high based on the low volume of complaints and grievances received in response to our request for those items. However, provider feedback may also be impacted by the unique interrelationships that exist between University Health Care, Inc. (Passport), the Partnership Council, the Board of University Health Care, Inc. and the provider/owners of the health plan. 2) Passport written complaints and grievances policies and procedures appear to be in compliance with applicable federal and state regulations and the provisions of the contract between DMS and Passport. However, our analysis was limited to the requirements of the initiative, which did not include an analysis of every process or requirement within the regulations. 3) There is evidence that Passport's monitoring of and communication with some of its subcontractors was inadequate during the audit window. In particular, Passport did not adequately monitor the escalated dental provider complaints. The contract between MCNA and Passport indicates in section 2.1.2 that "UHC (Passport) shall operate, at its own expense, reasonable quality assurance and utilization review protocols and Member grievance programs (collectively, the "UR/QA Programs)." It would appear this process either was not implemented or was ineffective, resulting in the same provider bringing the same escalated complaint to Passport Health Plan against the then current third party administrator for dental claims. PHP has indicated that it has exercised its right to terminate the contract with MCNA effective 3/21/12 and informed us that they have implemented appropriate contract monitoring strategies.

Objective #	Objective	Page #	Observations, Findings or Recommendations
			4) It appears that both third party administrators for dental services may not have been in compliance with the requirement to "stay" recoupments until a complaint is resolved, that PHP has not closely monitored subcontractor appeals, nor has PHP performed effective utilization review/quality assurance programs. 5) There appears to be a significant number of member complaints related to the auto assignment process. Passport staff indicated that when a member is enrolled, if that member fails to select a primary care provider, then the member will be "auto assigned" to a provider based on a number of criteria including previous relationship with that provider, current family member assignments and geographic factors. Passport may want to evaluate the effectiveness of this process based on the number of complaints being received.
1E	Business Relationships	100	1) UHC provided a limited number of policies and procedures that appears to be in effect during the examination window. In fact, many of the documents provided were newly drafted in 2011. In responding to our requests for policies and procedures in effect during the examination window, UHC responded as follows: • A board charter was not identified. • A board member appointment policy was not identified. • A board member termination policy was not identified • Term limits were not identified • An expense reimbursement policy was not identified. • A gift/gratuities policy was not identified • An in-kind payment policy was not identified • A perquisite /fringe benefit policy was not identified Additionally, we were unable to locate within board meeting minutes a process to formally adopt Passport Health Plan policies and procedures. 2) Although a travel expense policy is now in effect, including a provision which requires that travel expenses of the vice president and CEO will be reviewed quarterly, it did not appear the board has established any expense limits requiring board approval, thresholds that would require review regardless of position, or an alternative approval or oversight process for areas that may not have adequate oversight, controls, or supervision. PHP did indicate that travel requires prior approval. 3) UHC provided a limited number of Partnership Council policies and procedures that appears to be in effect during the examination window. In responding to our requests for policies and procedures in effect during the examination window, UHC did not provide the following: • A Partnership Council board charter

Objective #	Objective	Page #	Observations, Findings or Recommendations
			• Educational background requirements • Expense reimbursement • Gift/gratuities policy • In-kind payment policy 4) Educational and experience requirements for application to the Partnership Council were not outlined in the Partnership Council Application and no policy was provided by UHC that outlined the education/experience requirements for the various Partnership Council positions.
1F	Supplemental Payments	132	1) Provisions of the UHC contract require that "in establishing payments for teaching hospitals in its Contractor's Network, the Contractor shall recognize costs for graduate medical education, including adjustments required by KRS 205.565 and 907 KAR 10:825." A specific methodology for computing GME payments is included at 907 KAR 10:825. It does not appear that the health plan is computing GME payments in accordance with 907 KAR 10:825, which requires cost data from the facility to be considered. During meetings with health plan management, we asked for an explanation on how the then current methodology was determined. They described that there was an agreed upon aggregate payment amount that was determined in 1997. A distribution formula was then developed by an actuarial consultant that achieved the desired payment level for the three eligible facilities. 2) The GME distribution formula developed by the plan's consultant has been used since it was originally developed, with only minor adjustment. According to the health plan management, there have been adjustments to the original calculation methodology. "The first is to index the payments to increases in UHC's revenue pmpm. The second is to pay all facilities at the same rate per resident." All three facilities now use the Norton rate. 3) During on-site activities at PHP, we inquired whether the health plan had ever requested authorization from DMS regarding the methodology used to compute payments. UHC management indicated that they "never walked through the calculations with DMS." DMS confirmed that it had not been advised of the approach used by PHP. PHP should work with DMS to adjust the GME formula, if such an adjustment is determined to be necessary. 4) Medical education payments to the UofL Research Foundation were restructured effective June 30, 2011. We understand that the restructured program is based on an Upper Payment Limit methodology. Furthermore, we understand that PHP's involvement in the new program is limited, in that payments made to the Foundation are computed outside of PHP's domain, and funds of equal amounts are added to PHP's capitation payments from DMS. 5) UHC reported that ME payments were included as medical expenses in the databook used to compute the capitation rate ranges. Because this payment program is not addressed by the contract between DMS and UHC, it appears that it is a discretionary expenditure. DMS has confirmed that these are

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			permissible expenditures. 6) UHC personnel reported that it is their understanding that the payments were used to "support medical education in general," and thus, there was no agreement between UHC and the UofL Research Foundation on how UHC expected the funds to be used. Even if it were agreed between the two parties that the funds were to "support medical education in general," the terms should be memorialized in documentation maintained by both parties. Since ME payments have been discontinued, our observations regarding ME payments only apply to periods prior to the discontinuation of the ME payments. However, we believe it is appropriate for UHC to apply this concept to any discretionary payments or payment programs authorized in the future. 7) During a January 18, 2012, interview with medical school personnel, we requested information concerning how ME payments have been used. We understand that under a "clinic teaching agreement," all revenues received by the medical school are to be assigned to the UPA. Medical school personnel indicated that a portion of the ME funds (approximately $2 million annually) are allocated to various departments, with the remaining deposited into an account controlled by the Executive Vice President for Health Affairs (EVPHA). This position is currently held by Dr. David Dunn, who assumed his responsibilities as of July 1, 2011. 8) Over the course of several interviews and discussions with medical school representatives, we were informed that the University Board of Trustees (UBT) has oversight responsibilities for all University budgets and all approved functions. Authority of the UBT is delegated to department chairs, administrators, and executives (i.e., Agents of the UBT) within the University. Medical school personnel indicated that there are multiple accountability and transparency controls at the University, including annual audits of its consolidated financial statements, internal audit functions, ongoing compliance related activities, and other external functions. We reviewed the materials on The UofL Audit Services Web site (see http://louisville.edu/audit/) indicates "Audit Services reviews and evaluates the adequacy and effectiveness of the systems of internal control provided by the University and its affiliated corporations." Based on the potential for public interest issues related to the disposition of non-claim specific financial transactions with Passport, we recommend that the UofL Research Foundation consider a review by Audit Services to assess the risks and control environment related to such payments and to confirm that there is the requisite level of transparency, accountability, and oversight of these funds. 9) The UofL Executive Vice President for Health Affairs oversees the account where medical education funds are deposited. The University provided an overview of revenue and expenses from that account between 2004 and 2010. Based on funds deposited and expended for that period (i.e., irrespective of the beginning balance for 2004), the documentation from the University indicates a surplus of approximately $6 million. We requested the beginning balance for 2004, as well audit trail detail through 2011 for 14 of 40 cost centers. Of the 14 cost centers selected for review, staffing costs were seen regularly either in

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			recruitment or in reimbursement for salary. Of note, in SFY's 08 - SFY 2011, the amount shown for the Health Affairs Office has grown from $361,335 to $2,054,140 where as reimbursement for the Medicare Compliance Office and Privacy Office was discontinued during those years. In cost center "Anatomy - Fac recruitment" there was a payment of greater than $1.1 million made in SFY 2011 that was outside of the period supported by back-up documentation, and is much higher than prior payments for recruitment activities. 10) UHC reported that safety-net payments are included as medical expenses in the databook used to compute the capitation rate ranges. Because this payment program is not addressed by the contract, it is a discretionary expenditure. DMS has confirmed that these are permissible expenditures. 11) UHC personnel reported that it is their understanding that the safety-net payments were used to offset the cost of indigent care, and thus, there was no agreement between UHC and the eligible entities on how the funds were to be used. Even if it were agreed that funds were be directed to “indigent care” in general, we believe the terms should be memorialized in documentation maintained by both parties. 12) It is our understanding that Safety-Net payments to the UofL Primary Care Center have been restructured effective June 30, 2011. We understand that the restructured payments result in a net-decrease to UofL Primary Care. 13) Safety-net payments made to the UofL Primary Care Center were retained by the groups (i.e., UPA) that comprise the physician faculty at the UofL. UPA is the entity that holds the master lease with the University Faculty Office Building LLC. Please refer to the Appendix for additional information. 14) There appears to be limited availability of documentation from PHP for certain non-claim benefit expenditures. Payment programs for Healthy for Life Clinics, Pediatric Forensic Medicine, and the SANE programs are not described in the contract with the Department. Therefore, these payments should be classified as discretionary expenditures. DMS has confirmed that these are permissible expenditures. 15) All payment programs should be documented in contracts, provider manuals, regulations, and/or the Medicaid State Plan. 16) Policy and decision-makers from the Executive and Legislative branches of the Commonwealth may wish to consider how scarce supplemental funds should be leveraged in the community. Absent clearly defined parameters, receiving entities will continue to use such funds according to the prudence of their organization unless otherwise directed by federal statutes or regulations, Revised Statutes or Administrative Regulation of the Commonwealth. 17) The documentation submitted by PHP to support the non-claim payment calculations is insufficient to

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			document that payments made are in compliance with applicable guiding requirements. We recommend that all calculation components cite the authorization/guiding parameters. We found certain factors used within the analyses that did not contain or reference any source information (e.g., eligibility categories, etc). 18) Because UHC makes payments to eligible providers under the Intensity Operating Allowance and the Urban Trauma Center programs, they should maintain supporting documentation. Supporting documentation should include calculations, and DMS authorization. PHP should maintain such documentation, and update on a routine basis to support any payments made to providers. Furthermore, any such payments should be fully documented in the contract with DMS.
2A	Passport's Lines of Business/Cost Allocation Analysis	142	1) Cost allocation plans were not provided that would describe and illustrate how Passport ensures the accuracy of expenditures included in its financial reporting documents or in the data used to prepare capitation rate ranges. Based on the unavailability of such information, we believe that there is an elevated risk that expenses have not been properly reported. 2) Concerns were noted with the potential accuracy of the summary of claims submitted and adjudicated by AMHP. Specifically, the ratio of claims submitted to claims adjudicated and the accuracy of interest payments. 3) No claims payment timeliness data was provided by other Passport subcontractors.
2B	Best Practices	151	1) It does not appear that PHP had appropriate mechanisms in place to monitor financial reporting during the period being analyzed. No documentation has been provided to suggest that monitoring of financial reporting after the transition from AmeriHealth Mercy to Passport is being considered. 2) Passport's "Oversight of Delegated Activities" policy is outdated and does not address essential components. 3) Changes to the formula for calculating MLRs for plan years 2011, 2012, and 2013 have been recommended by the NAIC. PHP has indicated that it is reviewing the NAIC guidance on the determination of administrative costs and will work to ensure PHP is consistent with DMS policy and definition of MLR. 4) Based on 2009 data, the Milliman report established an MLR benchmark for CMS Region 4, in which Kentucky is a member, at 88 percent. 5) Selected best practices from the Kaiser report indicated areas in which there may be opportunities to reduce costs and improve member care and experience.

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			6) Passport did not provide any cost allocation or savings information to determine if any of their methods or measures could be compared with general business cost allocation and savings best practices.
2C	Selection of Subcontractors	165	1) Based upon apparent inconsistencies in subcontractor reporting for purposes of these analyses, it appears that PHP might not have consistently applied the contract definition of the term "Subcontractor" throughout its business processes during the examination period. Documentation and information received from the health plan suggests that the terms "vendor" and "subcontractor" have, at times, been used interchangeably and thus contract compliance with terms applicable to subcontractors, and tracking and reporting on subcontractors, appears to be an issue for the health plan as a result of this apparent inconsistency. It is important that PHP develop a clear understanding on which of the contracts constitute "subcontractor" services per terms of the contract between DMS and UHC. The likelihood of compliance becomes less likely as more entities are involved in the PHP model, and the more time that elapses without such agreement. PHP has indicated that they are working with DMS to obtain a clear understanding of the definition of a subcontractor. 2) PHP did not receive the Department's formal written approval for some subcontractor contract executions and/or amendments during the period between July 1, 2008 and June 30, 2011. 3) We have not received documentation to indicate that PHP has formalized subcontractor selection criteria, methodology, or conflict of interest/related party policies and procedures. Furthermore, we were unable to confirm that policies and procedures exist to identify, mitigate, and report conflicts of interest or related parties. The PHP business model, which is an integrated provider-sponsored delivery system, comes with increased risk of conflicts of interest by the very definition of the model. This increased risk should not imply an indictment of the model. However, it does require added responsibilities of oversight, detection, monitoring, and reporting in a highly transparent environment, the success of which depends heavily on the strength of entity-wide policies and procedures. 4) We identified several subcontractor relationships that might require conflict of interest or related party mitigation and/or evaluation by the Department to determine the appropriate next steps. 5) Analysis of documentation indicates that certain related party disclosures were submitted to the Department only during the period between July 1, 2009 and June 30, 2010 and only for two subcontractors, MCNA and PerformRx. 6) We identified subcontractors who were not properly registered with the Secretary of State at some point during the contract period(s). Although AMHP stated that it was properly registered for a period of time, the Secretary of State did not confirm this statement and agreed with our findings. PHP should consult with DMS to determine the appropriate next steps, if any.

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2D	Methodology of Payments to Subcontractors	175	1) Based upon our review of the provider contracts effective between July 1, 2008 and June 30, 2011, these contracts appear to all contain standard language within the body of the contract, with the reimbursement terms or other terms specific to the provider in the appendices of the contract. With the exception of PCP, all appear to be FFS based contracts with a reference to a fee schedule. The PCP contract appears to reimburse the provider at a PMPM rate for specific services identified in one of the appendices. The PCP provider is further reimbursed on a FFS basis for specific procedures not covered under the PMPM rate. This list of procedures is clearly identified in Appendix C. Selected eligibility groups are also reimbursed on a FFS basis and as such, the PCP receives no capitation payment for these members. Finally, the PCP provider is eligible for certain incentive payments based on utilization and other practice characteristics. The PCP provider is provided a bi-monthly incentive payment to submit encounters detailing the PMPM services provided. 2) We identified within the Pharmacy Benefit Manager (PBM) contract a sub-contractor, Argus, to the PBM. This subcontract relationship, which appears to have been enacted in 2004 and modified in 2010, is to provide all family planning pharmaceutical products. Department policies expressly prohibit this type of subcontract unless expressly approved. This extensive contractor and subcontractor relationship required disclosure and approval by the Department. 3) The reimbursement provided to PerformRx is significant. Please note that we have not performed analysis to determine whether the services provided by PerformRx justify the rates received. If they have demonstrated return on investment through formulary management, rates for multiple source products, drug interchange activities, rebate agreements, and patient compliance programs that substantially reduce costs, then the reimbursement rates may be justified. With the relationship between AMHP and PerformRx being a consideration, and the likelihood that AMHP personnel who served in key management positions within the health plan may have participated in the contract negotiations with PerformRx, increased risk to both PHP and the Department exists. PHP has indicated that the negotiated contracts were reviewed by an outside consultant in order to reduce the risk associated with the related parties and Passport plans to reprocure these services in 2012. 4) The PBM contractor receives a pharmaceutical administrative fee of $0.513 per member per month (PMPM). This fee is intended to reimburse the subcontractor for the cost of submitting and collecting rebates associated with the pharmaceutical program. However, the PBM is only required to submit to Passport 40 percent of the rebates collected, for Medicaid and CHIP members, despite receiving an administrative fee for the costs of administering this program. The PBM was required to submit to Passport 90 percent of the collected rebate for Passport Advantage members. 5) Passport appeared to require in its subcontracts a “Kentucky Medicaid Program - Disclosure of Ownership and Control Interest Statement” and indicated that questions 1-12 were required to be

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			answered. For some subcontractors, this document may not have been completed. 6) Bonus and incentive payments are included in both subcontractor/vendor contracts and health care provider contracts. Such payments can be effective at driving quality and member and provider satisfaction. However, if not carefully evaluated and monitored, there may be limited value realized for the additional reimbursement. 7) There is a risk that PHP reimbursement for family planning services could be excessive. The AmeriHealth HMO family planning contract, paid utilizing a capitation reimbursement methodology, also includes a guaranteed minimum number of services and a minimum fee paid annually.
2E	Validity of Incentives	197	1) As described within PR 89.0, the PRP approval sign off includes the following individuals, presented in the order of the approval process: "Manager of Reporting & Data Analysis, AVP of Quality Improvement, PRP Rep, Manager of Provider Services, AVP of Provider Relations, Chief Financial Officer, Executive Director with copies going to VP of Medical Management, Director of Medical Management/Care Coordinator, and Manager of Provider Relations." The approval procedure for incentive payments based on PR 112.0 includes the following individuals, presented in the order of the approval process: "Executive Director, Chief Financial Officer, VP of Operations & Contracting, AVP of Provider Relations, Manager of Provider Services, PRP rep, with copies to VP of Medical Management, AVP of Quality Improvement, Director of Medical Management/Care Coordinator, Manager of Reporting & Data Analysis, and Manager of Provider Relations, the PRP [Senior Data Analyst] will submit all measure details and specs with each approval packet." PR 89.0 and PR 112.0 do not appear to include procedures to identify excluded providers (i.e., providers that are not eligible to participate in Medicaid or Medicare according to the DHHS Office of Inspector General), providers with open accounts receivable, or providers under investigation prior to distributing funds. Section III of the policy indicates that payments to terminated providers will be "reviewed on a case by case basis." PHP provided the following assurances to DMS: *"Yes, we do check the excluded provider list on the DMS web site. We compare the DMS excluded provider list against our Facets system on a monthly basis*." 2) Although both PR 89.0 and PR 112.0 include performance metrics that must be achieved in order to qualify for an incentive payment, the "minimum reductions" require only a modest improvement in order to qualify. We do not have enough information to determine whether the minimum reduction levels are established at an appropriate and beneficial level (i.e., with a positive return on investment).

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			3) The PCP workgroup has oversight responsibilities for the primary care PRP. Many of the physicians on the PCP workgroup are eligible to receive payments under the primary care PRP, making a potential environment for a conflict of interest. However, many of the participants that we interviewed indicated that detailed level data were never reviewed during PCP workgroup meetings. 4) 907 KAR 1:705 Section 6 requires that incentive payments "shall be an amount up to one (1) percent of the capitation payment and made annually by the department." PR 89.0 does not include information about how the funding pool is developed, and whether those payments are within the requirements of Section 6. Although PR 112.0 specifies the funding pool amounts, the policy does not indicate whether those payments are within the requirements of Section 6. It is not clear whether the requirements in 907 KAR 1:705 are exclusive to incentive payments made by DMS to a managed care entity or if the provisions extend to the incentive payments made by a managed care entity to its subcontractors. 5) The terms "bonus" and "incentive payment" seemed to be used interchangeably in PHP policy PR 112.0. Those terms should be clarified and utilized appropriately. 6) Based upon our review of provider contract templates, certain PCPs are eligible for bonus or incentive payments based on utilization and other practice characteristics. It appears that the PCP provider category may be eligible to receive a bi-monthly incentive payment to submit encounters detailing the PMPM services provided. However, there appears to be no requirement that encounters be submitted. Not requiring encounter submission appears contradictory to the goal of receiving encounter claims, which is reinforced by offering incentive payments. 7) "Bonus" and "incentive payments" are included in both subcontractor/vendor contracts and health care provider contracts. Such payments can be effective at producing savings and rewarding positive behavior. If not carefully evaluated and monitored, there may be limited value realized for the additional reimbursement. Incentives and bonus payments should be considered in relation to the value of the alternative. 8) The pharmacy benefit manager, PerformRx, receives reimbursement for actual provider payments, plus a PMPM amount for administration, fixed fees for incentive payments and other services provided and they retain 60 percent of the Medicaid rebates received by PerformRx. Because PerformRx is a related party to AMHP, and because AMHP held key management positions within the health plan, there is a potential increased risk that AMHP management personnel may have been involved in contract negotiations with PerformRx. PHP indicated that the contract negotiations were reviewed by an outside consultant. 9) The costs and benefits of incentive programs should be carefully considered to ensure that the Commonwealth receives the greatest value from these initiatives. The intent of the incentive programs

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			should be to (among other factors): • Increase access to patients • Incentivize primary care and specialist to accept new patients in outlying areas • Increase quality of care • Improve patient satisfaction • Efficiently manage the care delivery of Passport membership It is our observation that to incentivize by measuring improvement in these areas is beneficial if monitored, tracked and quantified in a manner that is approved by all parties involved. Incentives must be designed to reduce or avoid cost, or change behavior such that the change represents value to the program. If not structured properly, and without value driven metrics, incentive payments are simply another way to redistribute Medicaid funds. 10) There may be a risk that certain key health plan personnel (either corporate or local) participated in contract negotiations with related parties for contracts in effect during the audit window. Since the transition of embedded AMHP staff to UHC, the risk for future conflicts with related parties (i.e., PBM and family planning subcontractors) has been reduced. However, UHC should ensure that its conflict of interest policies are comprehensive, current, reinforced by management, and put into practice, to ensure the level of transparency requisite of a provider sponsored health plan. Any related party transactions should be reported to DMS prior to the execution of any contractual arrangements or payments made. 11) As described above, carefully designed incentive programs can be extremely valuable in a Medicaid health plan environment. However, we were unable to identify any criteria that were used to create the incentive programs. Many of the non vendor related incentives appear to have been requested by health plan management, without providing anything more than anecdotal information regarding their benefit. Similarly for vendor related incentives, we were unable to identify criteria used in establishing the programs. Health plan staff described that discussions were held among the parties and the programs were approved by the board. However, we cannot determine whether the incentives created value to the program. We observed that many of the incentives were easily obtainable, and were based on goals uncommon to Medicaid incentive plans. Certain incentive amounts appear to be high relative to the qualification criteria. However, without an understanding of the benefits (i.e., how costs were avoided or reduced) of the incentives it is not possible to definitively determine if those incentive amounts were worth the payment. PHP has indicated that it believes that the costs associated with the incentives are consistent with national averages.
3A-C	Analysis of Expenditures	205	1) It is not clear what processes, if any, Passport has in place to evaluate the level of completeness or the accuracy of the encounter data being submitted to DMS by its subcontractors on behalf of the health plan. We recommend that PHP develop a plan to ensure complete and accurate encounter data is available to DMS. 2) It is not clear what activities, if any, Passport engages in to assess the level of completeness or accuracy

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			of the encounter data being submitted by providers to the health plan. Since many of the capitated providers appear to be paid incentives to submit timely encounters, we recommend that PHP develop a plan to ensure complete and accurate encounter data is available to DMS. 3) We noted variances between the medical expenses reported on encounter claims to the medical loss ratio data submitted by the health plan. We recommend that PHP investigate, reconcile differences, and report findings to DMS. 4) The low provider response rate makes calculating the accuracy of the claims data difficult since it is unclear whether the responses received are representative of the potential errors in the universe of claims. There are tremendous benefits that can be realized from a claims validation study. Therefore, we recommend that Passport continue to pursue responses from providers, and update DMS with the results. In response to this recommendation, PHP also indicated the following: *We will put a process in place to periodically conduct an encounter review with our providers. The process will be similar to the process we followed during the audit when we were requested to conduct the claim validation.* *On a periodic basis (e.g., annually), we will notify providers of our claims validation project. To perform the claims validation, we will pull a sample of medical, dental, pharmacy and vision claims. Each claim in the sample will be reviewed to note whether the claims were for services not covered by PHP and billed to DMS. After the claims have been reviewed and notations made to the claim log that accompanies the claim sample, the claims log and sample claims will be sent to the providers for their review. Providers will be instructed to review the sample claims and respond on form whether the information maintained by PHP is correct or incorrect. If the information is not correct, PHP will research the claims sample to determine if the incorrect information pertains to one claim or reflects a problem with several claims. Appropriate action will be taken to correct the claim or claims.* 5) Of the approximately 6.8 million Passport pharmacy claims included in the MMIS universe, 5.6 million (or 82.4 percent) contained a billed amount equal to the paid amount. Generally, the billed amount (sometimes referred to as Usual and Customary, or "U&C") reflects a provider-specific mark up and is the price charged for a cash-paying customer. Payor-specific negotiated price adjustments or fee schedules are not reflected in this amount. We compared this information to the screen shots for the sample claims provided by Passport and in no case did the billed amount equal the paid amount. We did not note any issues with the paid amounts. While the paid amount is a critical element for both rate setting and financial reporting reconciliation functions, we recommend that PHP follow-up with DMS, HP, or other entities on this matter and correct the encounter files as appropriate. 6) There were 2,405 pharmacy claims included in the universe where the billed amount on the claim was zero but the claim paid greater than zero. All of these claims included paid dates prior to May 2007. We

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			recommend that PHP follow-up with DMS, HP, or other entities on this matter and correct the encounter files as appropriate. 7) One response received from a hospital provider indicated the header amount billed on the claim was incorrect. When we examined the screen shot of the claims data included in FACETS, it appears that the encounter data that HP has includes only the billed amount from the first line of a multiple detail line claim. It is unclear whether this is an isolated issue and to what degree this may impact other activities which utilize this information from the MMIS. We recommend that PHP follow-up with DMS, HP, or other entities on this matter and correct the encounter files as appropriate.
4A-D	Grant Award Process	236	1) Grant payments made by PHP during the engagement window are not described in the contract between the Department and UHC. Details regarding grant programs should be submitted to the Department and documented within the contract between the Department and UHC. 2) Grants other than the iHOP appear to have been made with insufficient oversight and with varying degrees of guidance. All grants that have been authorized by the Department should be addressed by a comprehensive grants policy and procedure. The policy and procedure should include requisite information such as the application process, eligibility criteria, goals and objectives, terms of use, award and payment processes, reporting, and post grant procedures to confirm that the funds have been properly used as authorized. The grants policy should also include the evaluation and award process, and board oversight responsibilities. The contract between the Department and UHC should describe how grant payments should be reported by the health plan, and how grants should be treated for purposes of reporting health plan medical and administrative expenses. A comprehensive list of grants should be maintained and made available to the public. The grant policy adopted in July 2011 should be reviewed to confirm that it meets or exceeds these requirements. 3) Grants paid by UHC are not required by the contract between the Department and UHC. As such, these payments are considered “discretionary”, which appear to have been made without the authorization of the Department. Therefore, we recommend that Passport seek guidance from the Department on the appropriate classification (i.e., medical or administrative) of the payments, and to request guidance regarding their permissibility.
5A-B	Utilization Practices	247	1) A comprehensive member termination policy was not provided by PHP or AMHP. Although we received member policies from AMHP, they do not provide a sufficient level of detail. Member set up, change, and termination policies and procedures should include details about the member aid categories and other specific information in the process. As an example, please refer to excerpts (steps III, IV, and V) from AMHP’s procedures document listed below. Step III does not include information about what reports are extracted and what happens to the reports after they are distributed to the member services staff. Step IV does not indicate what the error

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			reports are reconciled to, what happens to errors found during reconciliation, and does not describe the rationale for destroying reports after 18 months, which appears to be inconsistent with the requirements of the Contract to maintain documentation for a "period of not less than three (3) years after all matters pertaining to this contract (e.g., audit, settlement of audit exceptions, disputes) are resolved…" Step V does not describe the process used to "investigate the Kentucky State System", nor does it identify the system being investigated. The procedure document does not include discussion related to the quality assessment procedures performed throughout the process to ensure that information is accurately presented. III. *"The reports are extracted by the Enrollment Representative and distributed to the Enrollment staff and run on a daily basis."* IV. *"Daily error reports are reconciled daily, prior to the run of the next eligibility file. The reports are kept on hand for 18 months, and then destroyed."* V. *"Each day, the Enrollment Representative will investigate the Kentucky State system and reconcile the discrepancies on the Heatlhcare system, by the monthly billing deadline."* 2) The average costs per member for Passport appears to be comparable to the national average for total Medicaid expenditures per member. 3) For the Passport population, the use of the lower level of care codes (99281 and 99282) is trending downwards and use of the higher levels of care is increasing. This trend should be carefully monitored to ensure that ER costs are properly maintained. 4) There appears to be a trend of members with higher costs exiting Passport. However, the cause of the trend is inconclusive. We recommend that Passport continue to analyze the cause of the member changes and report findings to DMS. 5) Passport should continue to assess and analyze encounter and utilization data to ensure it is representative of the population, and that it includes the data elements required for proper monitoring and management of its enrollees. Data fields such as EOB codes for service denials and reason codes for membership changes are critical in understanding emerging trends and appropriately managing the Passport membership.
Appendix A	The University Faculty Practice Office Building		1) The average base rent for space occupied by University Medical Center (UMC), Inc is $32.41 per square foot whereas the base rent for *all other* spaces was$16.71 per square foot. The differential between the highest and lowest rates spanned from $26.71 to $29.57 over the four base

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years. Summary statistics for the four years of rental rates are as follows:

<table>
<tr><th>FPB Rent Per Square Foot</th><th>Year 1</th><th>Year 2</th><th>Year 3</th><th>Year 4</th></tr>
<tr><td>Minimum</td><td>$12.00</td><td>$12.00</td><td>$12.36</td><td>$12.73</td></tr>
<tr><td>Maximum</td><td>$38.71</td><td>$39.87</td><td>$41.07</td><td>$42.30</td></tr>
<tr><td>Median</td><td>$15.44</td><td>$15.66</td><td>$16.30</td><td>$17.14</td></tr>
<tr><td>Average</td><td>$19.58</td><td>$19.66</td><td>$20.28</td><td>$21.19</td></tr>
</table>

Based on a non-scientific review of available similarly rated spaces, the rental rates paid by tenants in the FPB are similar to those in the Louisville, Kentucky market.

2) There is a provision contained in the Master Lease that indicates a three percent inflationary adjustment will be applied to the base rent. However, based on the information provided, the inflationary adjustment is not universally applied.

3) We have not identified conditions, terms of use, restrictions, or other prohibitions (collectively referenced as “Conditions”) placed on payments received for eligible services provided or costs eligible for reimbursement from Medicaid via the fiscal agent contractor, or those administered by Passport, other than as described in federal statutes or regulations, or Revised Statutes or Administrative Regulation of the Commonwealth of Kentucky, although this does not constitute a legal opinion.

4) Although we were informed that the debt service is paid through leases based on triple net pricing, the Master Lease suggests that another arrangement may be used instead. The lease indicates that the Landlord is responsible for the operational and maintenance costs of the building. It is unclear whether there are other agreements that may exist among the entities that provide additional information regarding revenue and cost arrangements. We were informed by UPA that the Landlord costs for operations and maintenance are computed into the sublease arrangements.

5) Public records searches ordered by Myers and Stauffer found nothing to dispute any of the information
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Objective #	Objective	Page #	Observations, Findings or Recommendations
			on the Landmark companies' Web page, or in the information provided by Mr. Lampasona. Furthermore, Mr. Lampasona stated that there is no relationship or common ownership between Landmark or any entity other than the Checota family, including any physician or physician group at the UofL. 6) UPA was unable to locate certain documents relating to the request for proposal, the evaluations, and the scoring sheets for the bidder proposals received for the development of the FPB. They provided a summary of proposals, which included an overview of three bids. During the interview of Mr. Lampasona (Landmark), he indicated that he believed there were eleven bids. We requested that he attempt to locate documents to confirm his recollection. He was unable to locate other documents. We requested that UPA attempt to locate documents related to the bid. They indicated that they could not locate materials other than the aforementioned summary. Because these documents could not be located, we could not confirm that the final financial arrangements to develop the FPB were consistent with the terms and conditions as included in the original RFP. 7) Although it was stated in the KY Legislature Capital Projects and Bond Oversight Committee meeting minutes dated November 21, 2006, that no university funds would be used on the FPB, it appears that university funding was used for the initiative. Based on meeting minutes from the UofL Foundation Board of Directors meeting on September 28, 2006, it appears that the EVPHA may have contributed to the construction of the Faculty Practice Building. "Dr. Cook reported the sources of financing: • UPA • Executive Vice President for Health Affairs • University Hospital • PSCs • Ambulatory Surgery Center • Imaging LLC • Landmark Healthcare Facilities" Funds received for services performed at the UofL Primary Care Centers (i.e., UPA) may include Safety-net funding, which is described elsewhere in this report. Funds received by the Executive Vice President for Health Affairs may include Medical Education funds, which are described elsewhere in this report. It is important to note that we have not been engaged to opine on the permissibility of funding from any source, including those from the University. It should also be noted that the arrangements described during the Bond Oversight Committee meeting may not reflect the actual final financing plan for the FPB. 8) Because of the complexities involved in the transactions, including the financing and operations of the FPB, and the relationships among entities (i.e., the university and its faculty physicians), we recommend

Objective #	Objective	Page #	Observations, Findings or Recommendations
			that the University Audit Services group thoroughly evaluate the funding sources, the transactions, relationships, and operational aspects of the FPB.

RESPONSE FROM PASSPORT HEALTH PLAN

PASSPORT HEALTH PLAN

5100 COMMERCE CROSSINGS DRIVE
LOUISVILLE, KY 40229
502-585-7900 / 800-578-0603
WWW.PASSPORTHEALTHPLAN.COM

May 24, 2012

Neville Wise
Acting Commissioner
Department for Medicaid Services
Cabinet for Health and Family Services
275 East Main Street
Frankfort, Kentucky 40601

Subject: Examination of Passport Health Plan dated April 30, 2012

Dear Commissioner Wise:

Thank you for the opportunity to provide this response to the report associated with the above-described examination. David Henley and I also appreciate the time you, Tammy Bullock and the auditors provided to us to review the report in detail during our meeting on March 23, 2012. As you know, we approached this examination in an open and forthright manner and we will utilize your recommendations to continue our efforts to improve the organizational effectiveness of Passport Health Plan (PHP).

We have noted that the matters identified in this examination were consistent with, and substantially the same as, those identified by the Auditor of Public Accounts (APA) in her examination dated November, 2010. We appreciate the comments included in this examination that recognize the many changes implemented within PHP since the issuance of the APA's report.

Passport Health Plan is unique among the managed care organizations doing business within the Commonwealth of Kentucky. PHP is a non- profit Medicaid health maintenance organization and a Kentucky-based company. It is sponsored by five leading non-profit health care organizations and employs approximately 250 Kentuckians. Working with its providers, PHP provides health benefits for over 170,000 of our most vulnerable citizens. The National Committee for Quality Assurance (NCQA) has ranked Passport Health Plan as the 13th best Medicaid Health Plan in the country. That ranking is based on a combination of clinical performance, member satisfaction, and accreditation status.

PHP has undergone extensive regulatory scrutiny during the past eighteen months. The Plan has been examined by the Department of Insurance on two occasions, reviewed by IPRO for contractual compliance also on two occasions, undergone two accreditation reviews by the NCQA and two independent external audits. In all of these cases, PHP has been found to not only be in compliance with its contractual obligations, but in the case of the NCQA to be operating at a very high level comparable to the top Medicaid health plans in the United States.

We understand that this examination was conducted by the Department in an effort to be responsive to the corrective action plan issued by the Governor on December 1, 2010 and to appropriately exercise its oversight responsibility with respect to all of the managed care organizations doing business in the Commonwealth. In our opinion, the completion of this examination, together with Passport's commitment to appropriately implement any new recommendations, brings Passport into full compliance with the corrective action plan and will allow the Governor to deem our obligations thereunder as being met.

Our Board of Directors, Partnership Council, providers, many advocates and our dedicated staff, look forward to continuing to serve the Commonwealth of Kentucky through our commitment to our mission of improving the health and quality of life of our members.

Sincerely,

Mark B. Carter
Chief Executive Officer

Myers and Stauffer LC
Certified Public Accountants

Response From the Department for Medicaid Services (DMS)

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

275 East Main Street, 6W-A
Frankfort, KY 40621
502-564-4321
502-564-0509
www.chfs.ky.gov

Audrey Tayse Haynes
Secretary

Neville Wise
Acting Commissioner

DEPARTMENT FOR MEDICAID SERVICES RESPONSE TO MYERS AND STAUFFER'S PASSPORT EXAMINATION MAY 24, 2012

As a result of the Auditor of Public Accounts (APA)'s examination of University Health Care, Inc., dba Passport Health Plan, released in November 2010, the Department for Medicaid Services (Department) issued a Request for Proposal (RFP) in February 2011. The RFP's primary focus was to perform a comprehensive assessment of Passport, including an examination of the efficiency and appropriateness of Passport's expenditures as necessary to provide quality health care services to Medicaid members. The Department subsequently contracted with Myers and Stauffer LC to carry out the RFP objectives and report their findings and observations to the Department.

Due to efforts by the Department and Passport Health Plan, many changes have occurred since November 2010 relative to the operations and management of the health plan. The Department has strengthened the oversight and monitoring requirements of Passport Health Plan through changes to the contract between the Cabinet and UHC, Inc., and is working collaboratively with the management of Passport to ensure the plan's ongoing compliance. The Department has provided the following responses to the Observations and Findings noted by the auditors in their Summary of Findings and Observations on page 248 this report.

The Department expects to incorporate additional contract language that will address the findings contained in this report.

NOTE: the "audit window" referenced in the Myers and Stauffer report below refers to the period July 1, 2008 through June 30, 2011.

1A: Business Plans, Observations and Findings

1) The absence of a formal business plan during the audit window left the health plan vulnerable to be operated as the management in place deemed appropriate. Health plan administration and operations were not adequately documented during the audit window. During that period, there were few, if any policies and procedures in place specific to Passport Health Plan that would have

guided and provided boundaries and limitations necessary for the appropriate management of the plan. PHP has indicated that they intend to address the lack of a formal business plan in the future. Additionally, the health plan has developed administrative and operational policies and procedures, subsequent to the audit window.

2) During the audit window, there were no specific provisions described in the contract between DMS and UHC for UHC to submit a comprehensive business plan. There were no specific requirements that UHC request DMS' authorization or approval of changes to the business plan. DMS addressed this observation by establishing requirements for the 2012 contract.

3) By placing AMHP employees in high level positions of authority, including Executive Director of Passport Health Plan and Chief Financial Officer of Passport Health Plan, there was insufficient monitoring of the TPA and other benefit subcontractors during the period covered by the audit. Because certain subcontractors of PHP are related parties of AMHP, there was significant risk of conflicts of interest or independence of those individuals (i.e., AMHP employees) who performed those functions prior to July 1, 2011.

4) During discussions with Passport employees who were AMHP employees prior to July 1, 2011, it was apparent that there was a significant amount of confusion regarding the roles and responsibilities related to the oversight of Passport's daily operations.

5) During the course of conducting interviews, we were informed that, during the period of our examination, a significant amount of uncertainty was present in the relationship between UHC/PHP and AMHP. This may have been as a result of discussions related to proposed rate reductions to the AMHP contract and/or modification to the methodology for calculating incentives paid to AMHP for cost savings initiatives.

6) In spite of contract provisions requiring that the Board of Directors have control over all policies and assets of Passport, interviews with former UHC staff revealed that they did not have direct access to the financial systems or to the bank accounts for the health plan during the period of the examination. PHP informed us that the new TPA agreement with AMHP contains service level agreements which include certain performance standards, appropriate oversight of TPA functions, and that assets of Passport are under the exclusive authority of UHC.

DMS Response: *DMS agrees that during the early portion of the examination period, the plan appears to have operated with a less rigorous management structure and level of internal control than would be expected by the Commonwealth. Passport has made significant efforts to address the lack of written policies and procedures necessary to guide the operations of the plan in a manner consistent with the goals of the Medicaid program, as well as developing a business plan consistent with the definition in this report. DMS also is in agreement with Passport's move to assert a greater degree of control over its own operations by restructuring its relationship with its TPA, AmeriHealth Mercy. DMS will*

continue to monitor the plan's efforts in this area.restructuring its relationship with its TPA, AmeriHealth Mercy. DMS will continue to monitor the plan's efforts in this area.

1B: Operations and Best Practices Observations and Findings

1) Internal Auditing does not appear to be listed in the functional area documentation submitted by Passport. Fraud, waste, and abuse activities are listed as an AmeriHealth Mercy's responsibility. PHP indicated they are now performing internal auditing and have hired a Director of Internal Audit.

2) Question B1.28 requests information regarding any health care service providers which may be owned by or affiliated with the owners of the health plan. Passport indicated their response to be No; however, a review of additional information provided by Passport provides an indication that several of the health plan sponsors are also health care providers.

3) There were conflicting responses given in section two of the survey regarding responsibility of functional areas. PHP has attempted to clarify these conflicts when possible.

4) Passport indicated that they do not subcontract with or use vendors who are subsidiaries or corporate related entities. It appears that this response may be inaccurate or Passport may have misunderstood the question.

5) Passport reported low utilization rates for emergency department visits per 1,000 members. PHP clarified that their response was indicative of the HEDIS measure.

DMS Response: *DMS notes the changes made by Passport relative to its internal auditing function and supports the move to develop and enhance internal auditing. DMS has no additional concerns relative to the findings in this section.*

1C: Revenue, Compensation and Expenditures Observations and Findings

1) Interviews with Passport indicated there currently are no formal quality assurance processes related to financial management or reporting. Passport should undertake to develop such processes and thoroughly document those processes.

2) We were unable to confirm the reasonableness of any methodology used to allocate shared administrative expenses between the Medicaid and the Medicare lines of business. Passport should document this process in order to ensure that future staff have a clear understanding of the allocation process and can demonstrate compliance.

3) During the period being analyzed, Passport reported paying approximately $227,000 in corporate and individual memberships. The largest of portion, over $200,000, was related to national and

state associations which Passport stated provided "industry information including legislation that affects Medicaid health plans". Passport should consider a policy that would require that the benefits of these memberships be demonstrated.

4) During the audit period, we noted sponsorships to entities that may not have provided a benefit to Passport Medicaid members. It appears that Passport is working to develop a more fiscally-responsible mind-set when the decision to make sponsorships is undertaken to ensure sponsorships are for the benefit of the health plan's members and has implemented a sponsorship and grants policy.

5) PHP indicated that it has implemented an executive compensation committee and engaged an outside consultant to ensure that it is able to adequately demonstrate that executive compensation has been thoroughly evaluated and is comparable to similar positions within the industry.

6) It was noted that certain former Passport employees received severance packages which could be considered generous. While Passport indicated that these severance agreements were arrived at based on sound legal advice, we recommend that Passport develop policies regarding severance packages including, which staff is eligible, under what circumstances will severance be paid and a reasonable basis for calculating the severance amount that is paid.

7) Because of the lack of certain written contracts for subcontractors, Passport may be in violation of 42 CFR 434.6 which requires that all subcontracts be in writing and for the subcontracts themselves to also meet the requirements of federal contracting laws. PHP provided commentary that disputed the consulting analysis from Krieg DeVault. DMS may wish to consult the Department's legal counsel on this matter.

DMS Response: *Accurate and timely financial information relative to the operations of the health plan and its provision of services to members of the Medicaid program is critical. In response to the findings in this section, DMS is requiring that Passport develop for DMS approval, written quality assurances processes that will ensure that the information being provided to DMS is accurate.*

DMS has already implemented additional reporting and approval requirements in the current Passport contract relating to compensation and expenditures.

DMS will seek legal counsel regarding the applicability of 42 CFR 434.6 regarding subcontracts as stated in this report and will implement contractual provisions addressing this issue as needed.

1D: Provider and Member Complaints and Concerns Regarding Passport Health Plan, Observations and Findings

1) It appears that provider satisfaction is relatively high based on the low volume of complaints and grievances received in response to our request for those items. However, provider feedback may also be impacted by the unique interrelationships that exist between University Health Care, Inc. (Passport), the Partnership Council, the Board of University Health Care, Inc. and the provider/owners of the health plan.

2) Passport written complaints and grievances policies and procedures appear to be in compliance with applicable federal and state regulations and the provisions of the contract between DMS and Passport. However, our analysis was limited to the requirements of the initiative, which did not include an analysis of every process or requirement within the regulations.

3) There is evidence that Passport's monitoring of and communication with some of its subcontractors was inadequate during the audit window. In particular, Passport did not adequately monitor the escalated dental provider complaints. The contract between MCNA and Passport indicates in section 2.1.2 that "UHC (Passport) shall operate, at its own expense, reasonable quality assurance and utilization review protocols and Member grievance programs (collectively, the "UR/QA Programs)." It would appear this process either was not implemented or was ineffective, resulting in the same provider bringing the same escalated complaint to Passport Health Plan against the then current third party administrator for dental claims. PHP has indicated that it has exercised its right to terminate the contract with MCNA effective 3/21/12 and informed us that they have implemented appropriate contract monitoring strategies.

4) It appears that both third party administrators for dental services may not have been in compliance with the requirement to "stay" recoupments until a complaint is resolved, that PHP has not closely monitored subcontractor appeals, nor has PHP performed effective utilization review/quality assurance programs.

   There appears to be a significant number of member complaints related to the auto assignment process. Passport staff indicated that when a member is enrolled, if that member fails to select a primary care provider, then the member will be "auto assigned" to a provider based on a number of criteria including previous relationship with that provider, current family member assignments and geographic factors. Passport may want to evaluate the effectiveness of this process based on the number of complaints being received.

DMS Response: *DMS requires that Passport demonstrate that it is adequately monitoring its subcontractors. DMS expects that Passport will note the deficiencies indicated relative to that monitoring process in this report and take necessary steps to address those deficiencies with its existing and future subcontractors.*

1E: Business Relationships, Observations and Findings

1) UHC provided a limited number of policies and procedures that appears to be in effect during the examination window. In fact, many of the documents provided were newly drafted in 2011. In responding to our requests for policies and procedures in effect during the examination window, UHC responded as follows:

- A board charter was not identified.
- A board member appointment policy was not identified.
- A board member termination policy was not identified
- Term limits were not identified
- An expense reimbursement policy was not identified.
- A gift/gratuities policy was not identified
- An in-kind payment policy was not identified
- A prerequisite /fringe benefit policy was not identified

Additionally, we were unable to locate within board meeting minutes a process to formally adopt Passport Health Plan policies and procedures.

2) Although a travel expense policy is now in effect, including a provision which requires that travel expenses of the vice president and CEO will be reviewed quarterly, it did not appear the board has established any expense limits requiring board approval, thresholds that would require review regardless of position, or an alternative approval or oversight process for areas that may not have adequate oversight, controls, or supervision. PHP did indicate that travel requires prior approval.

3) UHC provided a limited number of Partnership Council policies and procedures that appears to be in effect during the examination window. In responding to our requests for policies and procedures in effect during the examination window, UHC did not provide the following:

- A Partnership Council board charter
- Educational background requirements
- Expense reimbursement
- Gift/gratuities policy
- In-kind payment policy

4) Educational and experience requirements for application to the Partnership Council were not outlined in the Partnership Council Application and no policy was provided by UHC that outlined the education/experience requirements for the various Partnership Council positions.

DMS Response: *DMS notes that Passport has taken significant steps to address the implementation of policies and procedures required for effective operations of the health plan that existed during the period of the examination.*

1F: Supplemental Payments, Observations and Findings

1) Provisions of the UHC contract require that "in establishing payments for teaching hospitals in its Contractor's Network, the Contractor shall recognize costs for graduate medical education, including adjustments required by KRS 205.565 and 907 KAR 1:825." A specific methodology for computing GME payments is included at 907 KAR 1:825. It does not appear that the health plan is computing GME payments in accordance with 907 KAR 1:825, which requires cost data from the facility to be considered. During meetings with health plan management, we asked for an explanation on how the then current methodology was determined. They described that there was an agreed upon aggregate payment amount that was determined in 1997. A distribution formula was then developed by an actuarial consultant that achieved the desired payment level for the three eligible facilities.

2) The GME distribution formula developed by the plan's consultant has been used since it was originally developed, with only minor adjustment. According to the health plan management, there have been adjustments to the original calculation methodology. "The first is to index the payments to increases in UHC's revenue pmpm. The second is to pay all facilities at the same rate per resident." All three facilities now use the Norton rate.

3) During on-site activities at PHP, we inquired whether the health plan had ever requested authorization from DMS regarding the methodology used to compute payments. UHC management indicated that they "never walked through the calculations with DMS." DMS confirmed that it had not been advised of the approach used by PHP. PHP should work with DMS to adjust the GME formula to be in accordance with the KAR. PHP should consult with DMS to determine whether it is necessary to retrospectively compute GME payments according to the KAR and determine whether PHP has made potential overpayments to facilities.

4) Medical education payments to the UofL Research Foundation were restructured effective June 30, 2011. We understand that the restructured program is based on an Upper Payment Limit methodology. Furthermore, we understand that PHP's involvement in the new program is limited, in that payments made to the Foundation are computed outside of PHP's domain, and funds of equal amounts are added to PHP's capitation payments from DMS.

5) UHC reported that ME payments were included as medical expenses in the databook used to compute the capitation rate ranges. Because this payment program is not addressed by the contract between DMS and UHC, it appears that it is a discretionary expenditure. DMS has confirmed that these are permissible expenditures.

6) UHC personnel reported that it is their understanding that the payments were used to "support medical education in general," and thus, there was no agreement between UHC and the UofL Research Foundation on how UHC expected the funds to be used. Even if it were agreed between the two parties that the funds were to "support medical education in general," the terms should be memorialized in documentation maintained by both parties. Since ME payments have been discontinued, our observations regarding ME payments only apply to periods prior to the discontinuation of the ME payments. However, we believe it is appropriate for UHC to apply this concept to any discretionary payments or payment programs authorized in the future.

7) During a January 18, 2012, interview with medical school personnel, we requested information concerning how ME payments have been used. We understand that under a "clinic teaching agreement," all revenues received by the medical school are to be assigned to the UPA. Medical school personnel indicated that a portion of the ME funds (approximately $2 million annually) are allocated to various departments, with the remaining deposited into an account controlled by the Executive Vice President for Health Affairs (EVPHA). This position is currently held by Dr. David Dunn, who assumed his responsibilities as of July 1, 2011.

8) Over the course of several interviews and discussions with medical school representatives, we were informed that the University Board of Trustees (UBT) has oversight responsibilities for all University budgets and all approved functions. Authority of the UBT is delegated to department chairs, administrators, and executives (i.e., Agents of the UBT) within the University. Medical school personnel indicated that there are multiple accountability and transparency controls at the University, including annual audits of its consolidated financial statements, internal audit functions, ongoing compliance related activities, and other external functions. We reviewed the materials on The UofL Audit Services Web site (see http://louisville.edu/audit/) indicates "Audit Services reviews and evaluates the adequacy and effectiveness of the systems of internal control provided by the University and its affiliated corporations." Based on the potential for public interest issues related to the disposition of non-claim specific financial transactions with Passport, we recommend that the UofL Research Foundation consider a review by Audit Services to assess the risks and control environment related to such payments and to confirm that there is the requisite level of transparency, accountability, and oversight of these funds.

9) The UofL Executive Vice President for Health Affairs oversees the account where medical education funds are deposited. The University provided an overview of revenue and expenses from that account between 2004 and 2010. Based on funds deposited and expended for that period (i.e., irrespective of the beginning balance for 2004), the documentation from the University indicates a surplus of approximately $6 million. We requested the beginning balance for 2004, as well audit trail detail through 2011 for 14 of 40 cost centers. Of the 14 cost centers selected for review, staffing costs were seen regularly either in recruitment or in reimbursement for salary. Of note, in SFY's 08 - SFY 2011, the amount shown for the Health Affairs Office has grown from $361,335 to $2,054,140 where as reimbursement for the Medicare Compliance Office and Privacy

Office was discontinued during those years. In cost center "Anatomy - Fac recruitment" there was a payment of greater than $1.1 million made in SFY 2011 that was outside of the period supported by back-up documentation, and is much higher than prior payments for recruitment activities.

10) UHC reported that safety-net payments are included as medical expenses in the databook used to compute the capitation rate ranges. Because this payment program is not addressed by the contract, it is a discretionary expenditure. DMS has confirmed that these are permissible expenditures.

11) UHC personnel reported that it is their understanding that the safety-net payments were used to offset the cost of indigent care, and thus, there was no agreement between UHC and the eligible entities on how the funds were to be used. Even if it were agreed that funds were be directed to "indigent care" in general, we believe the terms should be memorialized in documentation maintained by both parties.

12) It is our understanding that Safety-Net payments to the UofL Primary Care Center have been restructured effective June 30, 2011. We understand that the restructured payments result in a net-decrease to UofL Primary Care.

13) Safety-net payments made to the UofL Primary Care Center were retained by the groups (i.e., UPA) that comprise the physician faculty at the UofL. UPA is the entity that holds the master lease with the University Faculty Office Building LLC. Please refer to the Appendix for additional information.

14) There appears to be limited availability of documentation from PHP for certain non-claim benefit expenditures. Payment programs for Healthy for Life Clinics, Pediatric Forensic Medicine, and the SANE programs are not described in the contract with the Department. Therefore, these payments should be classified as discretionary expenditures. DMS has confirmed that these are permissible expenditures.

15) All payment programs should be documented in contracts, provider manuals, regulations, and/or the Medicaid State Plan.

16) Policy and decision-makers from the Executive and Legislative branches of the Commonwealth may wish to consider how scarce supplemental funds should be leveraged in the community. Absent clearly defined parameters, receiving entities will continue to use such funds according to the prudence of their organization unless otherwise directed by federal statutes or regulations, Revised Statutes or Administrative Regulation of the Commonwealth.

17) The documentation submitted by PHP to support the non-claim payment calculations is insufficient to document that payments made are in compliance with applicable guiding requirements. We recommend that all calculation components cite the authorization/guiding parameters. We found

certain factors used within analyses that did not contain or reference any source information (e.g., eligibility categories, etc).

18) Because UHC makes payments to eligible providers under the Intensity Operating Allowance and the Urban Trauma Center programs, they should maintain supporting documentation. Supporting documentation should include calculations, and DMS authorization. PHP should maintain such documentation, and update on a routine basis to support any payments made to providers. Furthermore, any such payments should be fully documented in the contract with DMS.

DMS Response: *DMS has required as of July 1, 2011, that Passprot adjust the GME formula to be in accordance with 907 KAR 10:825.*

DMS will also require Passport to maintain and provide upon request, documentation which supports and clearly illustrates the calculation of non-benefit payments and the applicable authority.

DMS agrees with the recommendation that the UofL Research Foundation consider engaging its Audit Services to evaluate and make recommendations to the Foundation regarding opportunities to improve the transparency, accountability and oversight of funds received from Passport. DMS also agrees with the recommendation that agreements between the various UofL entities should be in writing.

2A: Passport's Lines of Business/Cost Allocation Analysis, Observations and Findings

1) Cost allocation plans were not provided that would describe and illustrate how Passport ensures the accuracy of expenditures included in its financial reporting documents or in the data used to prepare capitation rate ranges. Based on the unavailability of such information, we believe that there is an elevated risk that expenses have not been properly reported.

2) Concerns were noted with the potential accuracy of the summary of claims submitted and adjudicated by AMHP. Specifically, the ratio of claims submitted to claims adjudicated and the accuracy of interest payments.

3) No claims payment timeliness data was provided by other Passport subcontractors.

DMS Response: *DMS will require that Passport provide a written explanation of how shared costs were historically allocated across the health plan's lines of business and to demonstrate that the allocations were made in a reasonable and appropriate manner.*

DMS will require Passport and AMHP to address the concerns noted regarding the accuracy of the claims submissions and adjudication information submitted for this report.

2B: Best Practices, Observations and Findings

1) It does not appear that PHP had appropriate mechanisms in place to monitor financial reporting during the period being analyzed. No documentation has been provided to suggest that monitoring of financial reporting after the transition from AmeriHealth Mercy to Passport is being considered.

2) Passport's "Oversight of Delegated Activities" policy is outdated and does not address essential components.

3) Changes to the formula for calculating MLRs for plan years 2011, 2012, and 2013 have been recommended by the NAIC. PHP has indicated that it is taking steps to ensure compliance with the requirements of the NAIC.

4) Based on 2009 data, the Milliman report established an MLR benchmark for CMS Region 4, in which Kentucky is a member, at 88 percent.

5) Selected best practices from the Kaiser report indicated areas in which there may be opportunities to reduce costs and improve member care and experience.

6) Passport did not provide any cost allocation or savings information to determine if any of their methods or measures could be compared with general business cost allocation and savings best practices.

DMS Response: *DMS will require that Passport demonstrate that financial reporting is being monitored for accuracy through its quality assurance processes. DMS will also require Passport to provide an updated Oversight of Delegated Activities policy which meets the requirements set forth by DMS. Finally, as previously indicated, DMS will require Passport to provide information relative to cost allocations performed by the health plan.*

2C: Selection of Subcontractors, Observations and Findings

1) Based upon apparent inconsistencies in subcontractor reporting for purposes of these analyses, it appears that PHP might not have consistently applied the contract definition of the term "Subcontractor" throughout its business processes during the examination period. Documentation and information received from the health plan suggests that the terms "vendor" and "subcontractor" have, at times, been used interchangeably and thus contract compliance with terms applicable to subcontractors, and tracking and reporting on subcontractors, appears to be an issue for the health plan as a result of this apparent inconsistency. It is important that PHP develop a clear understanding on which of the contracts constitute "subcontractor" services per terms of the contract between DMS and UHC. The likelihood of compliance becomes less likely as more entities are involved in the PHP model, and the more time that elapses without such agreement.

PHP has indicated that they are working with DMS to obtain a clear understanding of the definition of a subcontractor.

2) PHP did not have received the Department's formal written approval for some subcontractor contract executions and/or amendments during the period between July 1, 2008 and June 30, 2011.

3) We have not received documentation to indicate that PHP has formalized subcontractor selection criteria, methodology, or conflict of interest/related party policies and procedures. Furthermore, we were unable to confirm that policies and procedures exist to identify, mitigate, and report conflicts of interest or related parties. The PHP business model, which is an integrated provider-sponsored delivery system, comes with increased risk of conflicts of interest by the very definition of the model. This increased risk should not imply an indictment of the model. However, it does require added responsibilities of oversight, detection, monitoring, and reporting in a highly transparent environment, the success of which depends heavily on the strength of entity-wide policies and procedures.

4) We identified several subcontractor relationships that might require conflict of interest or related party mitigation and/or evaluation by the Department to determine the appropriate next steps.

5) Analysis of documentation indicates that certain related party disclosures were submitted to the Department only during the period between July 1, 2009 and June 30, 2010 and only for two subcontractors, MCNA and PerformRx.

6) We identified subcontractors who were not properly registered with the Secretary of State at some point during the contract period(s). Although AMHP stated that it was properly registered for a period of time, the Secretary of State did not confirm this statement and agreed with our findings. PHP should consult with DMS to determine the appropriate next steps, if any.

DMS Response: *As stated, DMS is working with Passport to ensure the plan has a better understanding of the types of relationships which DMS considers to be a subcontractor and which meet the definition as outlined in the contract between DMS and UHC. DMS requires that Passport obtain prior written approval for all subcontractor relationships prior to contract execution.*

DMS will require that Passport demonstrate that all of its subcontractors, both historical and future, have been/are appropriately registered with the Kentucky Secretary of State to conduct business in the Commonwealth.

2D: Methodology of Payments to Subcontractors, Observations and Findings

1) Based upon our review of the provider contracts effective between July 1, 2008 and June 30, 2011, these contracts appear to all contain standard language within the body of the contract, with the reimbursement terms or other terms specific to the provider in the appendices of the contract. With

the exception of PCP, all appear to be FFS based contracts with a reference to a fee schedule. The PCP contract appears to reimburse the provider at a PMPM rate for specific services identified in one of the appendices. The PCP provider is further reimbursed on a FFS basis for specific procedures not covered under the PMPM rate. This list of procedures is clearly identified in Appendix C. Selected eligibility groups are also reimbursed on a FFS basis and as such, the PCP receives no capitation payment for these members. Finally, the PCP provider is eligible for certain incentive payments based on utilization and other practice characteristics. The PCP provider is provided a bi-monthly incentive payment to submit encounters detailing the PMPM services provided.

2) We identified within the Pharmacy Benefit Manager (PBM) contract a sub-contractor, Argus, to the PBM. This subcontract relationship, which appears to have been enacted in 2004 and modified in 2010, is to provide all family planning pharmaceutical products. Department policies expressly prohibit this type of subcontract unless expressly approved. This extensive contractor and subcontractor relationship required disclosure and approval by the Department.

3) The reimbursement provided to PerformRx is significant. Please note that we have not performed analysis to determine whether the services provided by PerformRx justify the rates received. If they have demonstrated return on investment through formulary management, rates for multiple source products, drug interchange activities, rebate agreements, and patient compliance programs that substantially reduce costs, then the reimbursement rates may be justified. With the relationship between AMHP and PerformRx being a consideration, and the likelihood that AMHP personnel who served in key management positions within the health plan may have participated in the contract negotiations with PerformRx, increased risk to both PHP and the Department exists. PHP has indicated that the negotiated contracts were reviewed by an outside consultant in order to reduce the risk associated with the related parties and the health plan plans to reprocure these services in 2012.

4) The PBM contractor receives a pharmaceutical rebate management fee of $0.513 per member per month (PMPM). This fee is intended to reimburse the subcontractor for the cost of submitting and collecting rebates associated with the pharmaceutical program. However, the PBM is only required to submit to Passport 40 percent of the rebates collected, for Medicaid and CHIP members, despite receiving an administrative fee for the costs of administering this program. The PBM was required to submit to Passport 90 percent of the collected rebate for Passport Advantage members.

5) Passport appeared to require in its subcontracts a "Kentucky Medicaid Program - Disclosure of Ownership and Control Interest Statement" and indicated that questions 1-12 were required to be answered. For some subcontractors, this document may not have been completed.

6) Bonus and incentive payments are included in both subcontractor/vendor contracts and health care provider contracts. Such payments can be effective at driving quality and member and provider

satisfaction. However, if not carefully evaluated and monitored, there may be limited value realized for the additional reimbursement.

7) There is a risk that PHP reimbursement for family planning services could be excessive. The AmeriHealth HMO family planning contract, paid utilizing a capitation reimbursement methodology, also includes a guaranteed minimum number of services and a minimum fee paid annually.

DMS Response: *DMS agrees that the health plan should evaluate the value received by Passport and the Commonwealth for the services that the plan procures through other vendors or subcontractors. Passport should also be prepared to provide the results of those evaluations and the decision-making processes relative to the payments made for those services.*

2E: Validity of Incentives, Observations and Findings

1) As described within PR 89.0, the PRP approval sign off includes the following individuals, presented in the order of the approval process: "Manager of Reporting & Data Analysis, AVP of Quality Improvement, PRP Rep, Manager of Provider Services, AVP of Provider Relations, Chief Financial Officer, Executive Director with copies going to VP of Medical Management, Director of Medical Management/Care Coordinator, and Manager of Provider Relations."

   The approval procedure for incentive payments based on PR 112.0 includes the following individuals, presented in the order of the approval process: "Executive Director, Chief Financial Officer, VP of Operations & Contracting, AVP of Provider Relations, Manager of Provider Services, PRP rep, with copies to VP of Medical Management, AVP of Quality Improvement, Director of Medical Management/Care Coordinator, Manager of Reporting & Data Analysis, and Manager of Provider Relations, the PRP [Senior Data Analyst] will submit all measure details and specs with each approval packet."

   PR 89.0 and PR 112.0 do not appear to include procedures to identify excluded providers (i.e., providers that are not eligible to participate in Medicaid or Medicare according to the DHHS Office of Inspector General), providers with open accounts receivable, or providers under investigation prior to distributing funds. Section III of the policy indicates that payments to terminated providers will be "reviewed on a case by case basis." PHP provided the following assurances to DMS:

   "*Yes, we do check the excluded provider list on the DMS web site. We compare the DMS excluded provider list against our Facets system on a monthly basis.*"

2) Although both PR 89.0 and PR 112.0 include performance metrics that must be achieved in order to qualify for an incentive payment, the "minimum reductions" require only a modest improvement in order to qualify. We do not have enough information to determine whether the minimum reduction levels are established at an appropriate and beneficial level (i.e., with a positive return on investment).

3) The PCP workgroup has oversight responsibilities for the primary care PRP. Many of the physicians on the PCP workgroup are eligible to receive payments under the primary care PRP, making a potential environment for a conflict of interest. However, many of the participants that we interviewed indicated that detailed level data were never reviewed during PCP workgroup meetings.

4) 907 KAR 1:705 Section 6 requires that incentive payments "shall be an amount up to one (1) percent of the capitation payment and made annually by the department." PR 89.0 does not include information about how the funding pool is developed, and whether those payments are within the requirements of Section 6. Although PR 112.0 specifies the funding pool amounts, the policy does not indicate whether those payments are within the requirements of Section 6. It is not clear whether the requirements in 907 KAR 1:705 are exclusive to incentive payments made by DMS to a managed care entity or if the provisions extend to the incentive payments made by a managed care entity to its subcontractors.

5) The terms "bonus" and "incentive payment" seemed to be used interchangeably in PHP policy PR 112.0. Those terms should be clarified and utilized appropriately.

6) Based upon our review of provider contract templates, certain PCPs are eligible for bonus or incentive payments based on utilization and other practice characteristics. It appears that the PCP provider category may be eligible to receive a bi-monthly incentive payment to submit encounters detailing the PMPM services provided. However, there appears to be no requirement that encounters be submitted. Not requiring encounter submission appears contradictory to the goal of receiving encounter claims, which is reinforced by offering incentive payments.

7) "Bonus" and "incentive payments" are included in both subcontractor/vendor contracts and health care provider contracts. Such payments can be effective at producing savings and rewarding positive behavior. If not carefully evaluated and monitored, there may be limited value realized for the additional reimbursement. Incentives and bonus payments should be considered in relation to the value of the alternative.

8) The pharmacy benefit manager, PerformRx, receives reimbursement for actual provider payments, plus a PMPM amount for administration, fixed fees for incentive payments and other services provided and they retain 60 percent of the Medicaid rebates received by PerformRx. Because PerformRx is a related party to AMHP, and because AMHP held key management positions within the health plan, there is a potential increased risk that AMHP management personnel may have been involved in contract negotiations with PerformRx. PHP indicated that the contract negotiations were reviewed by an outside consultant.

9) The costs and benefits of incentive programs should be carefully considered to ensure that the Commonwealth receives the greatest value from these initiatives. The intent of the incentive programs should be to (among other factors):

- Increase access to patients
- Incentivize primary care and specialist to accept new patients in outlying areas
- Increase quality of care
- Improve patient satisfaction
- Efficiently manage the care delivery of Passport membership

It is our observation that to incentivize by measuring improvement in these areas is beneficial if monitored, tracked and quantified in a manner that is approved by all parties involved. Incentives must be designed to reduce or avoid cost, or change behavior such that the change represents value to the program. If not structured properly, and without value driven metrics, incentive payments are simply another way to redistribute Medicaid funds.

10) There may be a risk that certain key health plan personnel (either corporate or local) participated in contract negotiations with related parties for contracts in effect during the audit window. Since the transition of embedded AMHP staff to UHC, the risk for future conflicts with related parties (i.e., PBM and family planning subcontractors) has been reduced. However, UHC should ensure that its conflict of interest policies are comprehensive, current, reinforced by management, and put into practice, to ensure the level of transparency requisite of a provider sponsored health plan. Any related party transactions should be reported to DMS prior to the execution of any contractual arrangements or payments made.

11) As described above, carefully designed incentive programs can be extremely valuable in a Medicaid health plan environment. However, we were unable to identify any criteria that were used to create the incentive programs. Many of the non vendor related incentives appear to have been requested by health plan management, without providing anything more than anecdotal information regarding their benefit. Similarly for vendor related incentives, we were unable to identify criteria used in establishing the programs. Health plan staff described that discussions were held among the parties and the programs were approved by the board. However, we cannot determine whether the incentives created value to the program. We observed that many of the incentives were easily obtainable, and were based on goals uncommon to Medicaid incentive plans. Certain incentive amounts appear to be high relative to the qualification criteria. However, without an understanding of the benefits (i.e., how costs were avoided or reduced) of the incentives it is not possible to definitively determine if those incentive amounts were worth the payment. PHP has indicated that it believes that the costs associated with the incentives are consistent with national averages.

DMS Response: *DMS believes that the requirements in 907 KAR 1:705 are exclusive to incentive payments made by DMS to a managed care entity and do not extend to the incentive payments made by a managed care entity to its subcontractors.*

3A-C: Analysis of Expenditures, Observations and Findings

1) It is not clear what processes, if any, Passport has in place to evaluate the level of completeness or the accuracy of the encounter data being submitted to DMS by its subcontractors on behalf of the health plan. We recommend that PHP develop a plan to ensure complete and accurate encounter data is available to DMS.

2) It is not clear what activities, if any, Passport engages in to assess the level of completeness or accuracy of the encounter data being submitted by providers to the health plan. Since many of the capitated providers appear to be paid incentives to submit timely encounters, we recommend that PHP develop a plan to ensure complete and accurate encounter data is available to DMS.

3) We noted variances between the medical expenses reported on encounter claims to the medical loss ratio data submitted by the health plan. We recommend that PHP investigate, reconcile differences, and report findings to DMS.

4) The low provider response rate makes calculating the accuracy of the claims data difficult since it is unclear whether the responses received are representative of the potential errors in the universe of claims. There are tremendous benefits that can be realized from a claims validation study. Therefore, we recommend that Passport continue to pursue responses from providers, and update DMS with the results. In response to this recommendation, PHP also indicated the following:

   "We will put a process in place to periodically conduct an encounter review with our providers. The process will be similar to the process we followed during the audit when we were requested to conduct the claim validation.

   On a periodic basis (e.g., annually), we will notify providers of our claims validation project. To perform the claims validation, we will pull a sample of medical, dental, pharmacy and vision claims. Each claim in the sample will be reviewed to note whether the claims were for services not covered by PHP and billed to DMS. After the claims have been reviewed and notations made to the claim log that accompanies the claim sample, the claims log and sample claims will be sent to the providers for their review. Providers will be instructed to review the sample claims and respond on form whether the information maintained by PHP is correct or incorrect. If the information is not correct, PHP will research the claims sample to determine if the incorrect information pertains to one claim or reflects a problem with several claims. Appropriate action will be taken to correct the claim or claims."

5) Of the approximately 6.8 million Passport pharmacy claims included in the MMIS universe, 5.6 million (or 82.4 percent) contained a billed amount equal to the paid amount. Generally, the billed

amount (sometimes referred to as Usual and Customary, or "U&C") reflects a provider-specific mark up and is the price charged for a cash-paying customer. Payor-specific negotiated price adjustments or fee schedules are not reflected in this amount. We compared this information to the screen shots for the sample claims provided by Passport and in no case did the billed amount equal the paid amount. We did not note any issues with the paid amounts. While the paid amount is a critical element for both rate setting and financial reporting reconciliation functions, we recommend that PHP follow-up with DMS, HP, or other entities on this matter and correct the encounter files as appropriate.

6) There were 2,405 pharmacy claims included in the universe where the billed amount on the claim was zero but the claim paid greater than zero. All of these claims included paid dates prior to May 2007. We recommend that PHP follow-up with DMS, HP, or other entities on this matter and correct the encounter files as appropriate.

7) One response received from a hospital provider indicated the header amount billed on the claim was incorrect. When we examined the screen shot of the claims data included in FACETS, it appears that the encounter data that HP has includes only the billed amount from the first line of a multiple detail line claim. It is unclear whether this is an isolated issue and to what degree this may impact other activities which utilize this information from the MMIS. We recommend that PHP follow-up with DMS, HP, or other entities on this matter and correct the encounter files as appropriate.

DMS Response: *DMS will require that Passport address the issues relative to the encounter data that has been submitted. DMS will request a response to DMS including any corrections.*

PHP should either document its existing encounter validation process or develop an encounter validation process. The new or revised validation process should be submitted to DMS for review and approval.

4A-D: Grant Award Process, Observations and Findings

1) Grant payments made by PHP during the engagement window are not described in the contract between the Department and UHC. Details regarding grant programs should be submitted to the Department and documented within the contract between the Department and UHC.

2) Grants other than the iHOP appear to have been made with insufficient oversight and with varying degrees of guidance. All grants that have been authorized by the Department should be addressed by a comprehensive grants policy and procedure. The policy and procedure should include requisite information such as the application process, eligibility criteria, goals and objectives, terms of use, award and payment processes, reporting, and post grant procedures to confirm that the funds have been properly used as authorized. The grants policy should also include the evaluation

and award process, and board oversight responsibilities. The contract between the Department and UHC should describe how grant payments should be reported by the health plan, and how grants should be treated for purposes of reporting health plan medical and administrative expenses. A comprehensive list of grants should be maintained and made available to the public. The grant policy adopted in July 2011 should be reviewed to confirm that it meets or exceeds these requirements.

3) Grants paid by UHC are not required by the contract between the Department and UHC. As such, these payments are considered "discretionary", which appear to have been made without the authorization of the Department. Therefore, we recommend that Passport seek guidance from the Department on the appropriate classification (i.e., medical or administrative) of the payments, and to request guidance regarding their permissibility.

DMS Response: *The Department agrees that PHP should consult with the Department prior to initiating grants. The Department will work with Passport to address the issues identified with respect to the PHP grant awards process including the appropriate classification of such expenditures.*

5A-B: Utilization Practices, Observations and Findings

1) A comprehensive member termination policy was not provided by PHP or AMHP. Although we received member policies from AMHP, they do not provide a sufficient level of detail. Member set up, change, and termination policies and procedures should include details about the member aid categories and other specific information in the process.

   As an example, please refer to excerpts (steps III, IV, and V) from AMHP's procedures document listed below. Step III does not include information about what reports are extracted and what happens to the reports after they are distributed to the member services staff. Step IV does not indicate what the error reports are reconciled to, what happens to errors found during reconciliation, and does not describe the rationale for destroying reports after 18 months, which appears to be inconsistent with the requirements of the Contract to maintain documentation for a "period of not less than three (3) years after all matters pertaining to this contract (e.g., audit, settlement of audit exceptions, disputes) are resolved…" Step V does not describe the process used to "investigate the Kentucky State System", nor does it identify the system being investigated. The procedure document does not include discussion related to the quality assessment procedures performed throughout the process to ensure that information is accurately presented.

III. "The reports are extracted by the Enrollment Representative and distributed to the Enrollment staff and run on a daily basis."

IV. "Daily error reports are reconciled daily, prior to the run of the next eligibility file. The reports are kept on hand for 18 months, and then destroyed."

V. "Each day, the Enrollment Representative will investigate the Kentucky State system and reconcile the discrepancies on the Heatlhcare system, by the monthly billing deadline."

2) The average costs per member for Passport appears to be comparable to the national average for total Medicaid expenditures per member.

3) For the Passport population, the use of the lower level of care codes (99281 and 99282) is trending downwards and use of the higher levels of care is increasing. This trend should be carefully monitored to ensure that ER costs are properly maintained.

4) There appears to be a trend of members with higher costs exiting Passport. However, the cause of the trend is inconclusive. We recommend that Passport continue to analyze the cause of the member changes and report findings to DMS.

5) Passport should continue to assess and analyze encounter and utilization data to ensure it is representative of the population, and that it includes the data elements required for proper monitoring and management of its enrollees. Data fields such as EOB codes for service denials and reason codes for membership changes are critical in understanding emerging trends and appropriately managing the Passport membership.

DMS Response: *DMS agrees with the recommendations made in this section and will evaluate the need for additional reporting requirements to address these areas.*

Appendix: The University Faculty Practice Office Building, Observations and Findings

1) The average base rent for space occupied by University Medical Center (UMC), Inc is $32.41 per square foot whereas the base rent for *all other* spaces was$16.71 per square foot.

The differential between the highest and lowest rates spanned from $26.71 to $29.57 over the four base years. Summary statistics for the four years of rental rates are as follows:

FPB Rent Per Square Foot	Year 1	Year 2	Year 3	Year 4
Minimum	$12.00	$12.00	$12.36	$12.73
Maximum	$38.71	$39.87	$41.07	$42.30
Median	$15.44	$15.66	$16.30	$17.14
Average	$19.58	$19.66	$20.28	$21.19

Based on a non-scientific review of available similarly rated spaces, the rental rates paid by tenants in the FPB are similar to those in the Louisville, Kentucky market.

2) There is a provision contained in the Master Lease that indicates a three percent inflationary adjustment will be applied to the base rent. However, based on the information provided, the inflationary adjustment is not universally applied.

3) We have not identified conditions, terms of use, restrictions, or other prohibitions (collectively referenced as "Conditions") placed on payments received for eligible services provided or costs eligible for reimbursement from Medicaid via the fiscal agent contractor, or those administered by Passport, other than as described in federal statutes or regulations, or Revised Statutes or Administrative Regulation of the Commonwealth of Kentucky, although this does not constitute a legal opinion.

4) Although we were informed that the debt service is paid through leases based on triple net pricing, the Master Lease suggests that another arrangement may be used instead. The lease indicates that the Landlord is responsible for the operational and maintenance costs of the building. It is unclear whether there are other agreements that may exist among the entities that provide additional information regarding revenue and cost arrangements. We were informed by UPA that the Landlord costs for operations and maintenance are computed into the sublease arrangements.

5) Public records searches ordered by Myers and Stauffer found nothing to dispute any of the information on the Landmark companies' Web page, or in the information provided by Mr. Lampasona. Furthermore, Mr. Lampasona stated that there is no relationship or common ownership between Landmark or any entity other than the Checota family, including any physician or physician group at the UofL.

6) UPA was unable to locate certain documents relating to the request for proposal, the evaluations, and the scoring sheets for the bidder proposals received for the development of the FPB. They provided a summary of proposals, which included an overview of three bids. During the interview of Mr. Lampasona (Landmark), he indicated that he believed there were eleven bids. We requested that he attempt to locate documents to confirm his recollection. He was unable to locate other documents. We requested that UPA attempt to locate documents related to the bid. They indicated that they could not locate materials other than the aforementioned summary. Because these documents could not be located, we could not confirm that the final financial arrangements to develop the FPB were consistent with the terms and conditions as included in the original RFP.

7) Although it was stated in the KY Legislature Capital Projects and Bond Oversight Committee meeting minutes dated November 21, 2006, that no university funds would be used on the FPB, it appears that university funding was used for the initiative. Based on meeting minutes from the UofL Foundation Board of Directors meeting on September 28, 2006, it appears that the EVPHA may have contributed to the construction of the Faculty Practice Building.

"Dr. Cook reported the sources of financing:

- UPA
- Executive Vice President for Health Affairs
- University Hospital
- PSCs
- Ambulatory Surgery Center
- Imaging LLC
- Landmark Healthcare Facilities"

Funds received for services performed at the UofL Primary Care Centers (i.e., UPA) may include Safety-net funding, which is described elsewhere in this report. Funds received by the Executive Vice President for Health Affairs may include Medical Education funds, which are described elsewhere in this report.

It is important to note that we have not been engaged to opine on the permissibility of funding from any source, including those from the University. It should also be noted that the arrangements described during the Bond Oversight Committee meeting may not reflect the actual final financing plan for the FPB.

8) Because of the complexities involved in the transactions, including the financing and operations of the FPB, and the relationships among entities (i.e., the university and its faculty physicians), we recommend that the University Audit Services group thoroughly evaluate the funding sources, the transactions, relationships, and operational aspects of the FPB.

DMS Response: *DMS has no additional comments relative to the information provided in the appendix of this report.*

The Department considers this report as another important step in our ongoing process of identifying, understanding, and correcting inefficiencies and missteps that can occur in the operation of managed care plans. Staff will study these findings and recommendations as we work to enhance our monitoring process over all the Department's managed care organizations. The Department strives to continuously evolve and develop strategies for structuring contracts and administrative activities to ensure accountability and transparency in program operation.

Sincerely,

Neville Wise
Acting Commissioner

01429

EXHIBITS

APPENDIX A:

FACULTY PRACTICE OFFICE BUILDING

Myers and Stauffer LC (MSLC) was engaged by the Department for Medicaid Services to perform an examination of Passport Health Plan, its subcontractors, and related subjects. The scope of the engagement was defined by the Department for Medicaid Services and does not mean an "audit" or "examination" as the terms are used and defined in the accounting profession. This engagement does not include attestation services. Myers and Stauffer was not engaged to express an "opinion," as that term is used in the accounting profession, on the Passport Health Plan, or the Faculty Practice Building and no such opinion is expressed.

The Department determined that the examination should include the following subjects:

- A comprehensive assessment of "Kentucky's sole-source, non-competitive managed-care provider for Region 3, University Health Care, d.b.a. Passport Health Plan";
- The efficiency and "appropriateness of expenditures as necessary to provide quality health care services to Medicaid eligible individuals"; and
- Issues related to fraud, waste, abuse and contract compliance.

This engagement was performed under the American Institute of Certified Public Accountants code of professional conduct for consulting engagements. Myers and Stauffer performed the engagement activities under the direction of the Department, which made all management decisions. The Department is responsible for the oversight of the Passport Health Plan and for determining the sufficiency of the activities completed for this engagement.

In furtherance of the objectives for this engagement, and to gauge the veracity of the public interest issues described earlier in this report (see General Approach and Methodology), DMS directed Myers and Stauffer to assess whether certain supplemental payments (i.e., medical education, graduate medical education, and/or safety-net payments) administered by Passport Health Plan contributed to the Department's goal of "providing quality health care services to Medicaid eligible individuals."

The Faculty Practice Building (FPB) is an example of how certain funds from supplemental payments administered by Passport and paid to various UofL affiliated entities, combined with other funds, have been used by the community to promote access to quality care. The FPB was created through combined resources and/or certain agreements between UofL faculty physicians, the UofL Foundation, UofL Research Foundation, the Executive Vice President for Health Affairs, the UofL School of Medicine, UofL Primary Care, and a private development firm.

Analysis of the Faculty Practice Building was completed to address the following sub-objectives:

- To describe the relationships, if any, among the entities that developed, manage, and/or occupy the FPB, including the organizations comprised by the UofL faculty physicians.

  For purposes of this analysis, the organizations comprised by the UofL faculty physicians include MSPA Services, Inc. (a.k.a MSPA or Medical School Practice Association); University Physicians' Group, Inc. (a.k.a. UPG or UofL Health Care); UPA Services, Inc. (a.k.a, UPA or University Physician Associates); and University of Louisville Physicians, Inc. (a.k.a. ULP).

- To describe the role and responsibilities of Landmark Healthcare Fund LLC, the developer of the building.

- To describe how a portion of the supplemental payments administered by Passport and received by eligible health care providers or entities contributed to the development and daily operation of the FPB.

Developing an Understanding

Myers and Stauffer prepared a "supplemental" data request that was submitted to PHP on January 18, 2012. We requested responses to numerous questions, many of which were extracted from the public issues related correspondence. We attempted to conference with Passport, sponsoring organizations, and representatives from the medical school to facilitate discussion, as well as to establish an environment where the participants could collaborate on responses to subjects that involved more than one entity (e.g., the medical school and Passport Health Plan, etc.)[1].

We were informed by PHP that the UofL Executive Vice President for Health Affairs (i.e., Dr. David Dunn) declined to participate since the subjects planned for discussion were covered by what was then a recently received subpoena to produce documents. Because a significant number of questions would have been directed to Dr. Dunn, his absence rendered this collaborative approach ineffective and we were forced to abandon it.

As an alternative to the group approach, we issued requests for information and/or conducted interviews with the individuals listed in the table below.

[1] Myers and Stauffer's role was to be limited to facilitating discussion of the topics, documenting responses, and scheduling follow-up activities if needed.

Name	Date	Mode	Position/Title
Michael Mitchell and Ralph Hall	1/18/2012	In Person	University of Louisville Physicians
Terry Gossum and Glenn Bossmeyer	1/18/2012	In Person	Former Employee of UofL; In-house Counsel for UofL
Larry Cook, MD	1/24/2012	In Person	Former Chairman of the UHC Board of Directors
Gregory Postel, MD	1/27/2012	Telephone	PHP Board Member
John Morse	1/31/2012	Telephone	UofL Primary Care Center
Steven Eisenberg	2/9/2012	Telephone	Attorney representing University Physicians Associates
Anthony Lampasona	2/9/2012	Telephone	Landmark Healthcare Properties Fund LLC

UofL Faculty Physicians

To understand how the FPB was developed and how it is leased and operated today, it is first necessary to understand the various organizations that are comprised of the physician faculty of the University. To establish an understanding of these groups, and to gain a historical perspective, Myers and Stauffer interviewed Dr. Gregory Postel on January 27, 2012[2].

Dr. Postel indicated that in the 1990s, there were many private, clinical professional service corporations (PSCs) who conducted the private clinical practice of the physicians who comprised the faculty at the UofL School of Medicine. The practices operated independently, despite all of the physicians also serving as faculty members. The physicians determined that an entity was needed to serve some central function among the PSCs.

In 1993, Medical School Practice Association, Inc. (MSPA) was incorporated as a Kentucky nonprofit corporation. In 2002, MSPA legally assumed the trade name "University Physicians Associates" (UPA). UPA conducted minimal commercial activity following its incorporation. Another entity, University Physicians' Group (UPG), was incorporated in 1999 as a nonprofit corporation with the intention of undertaking business activities on behalf of the clinical faculty. While it had some limited activity, it did not serve as the primary vehicle for collective business activities of the clinical

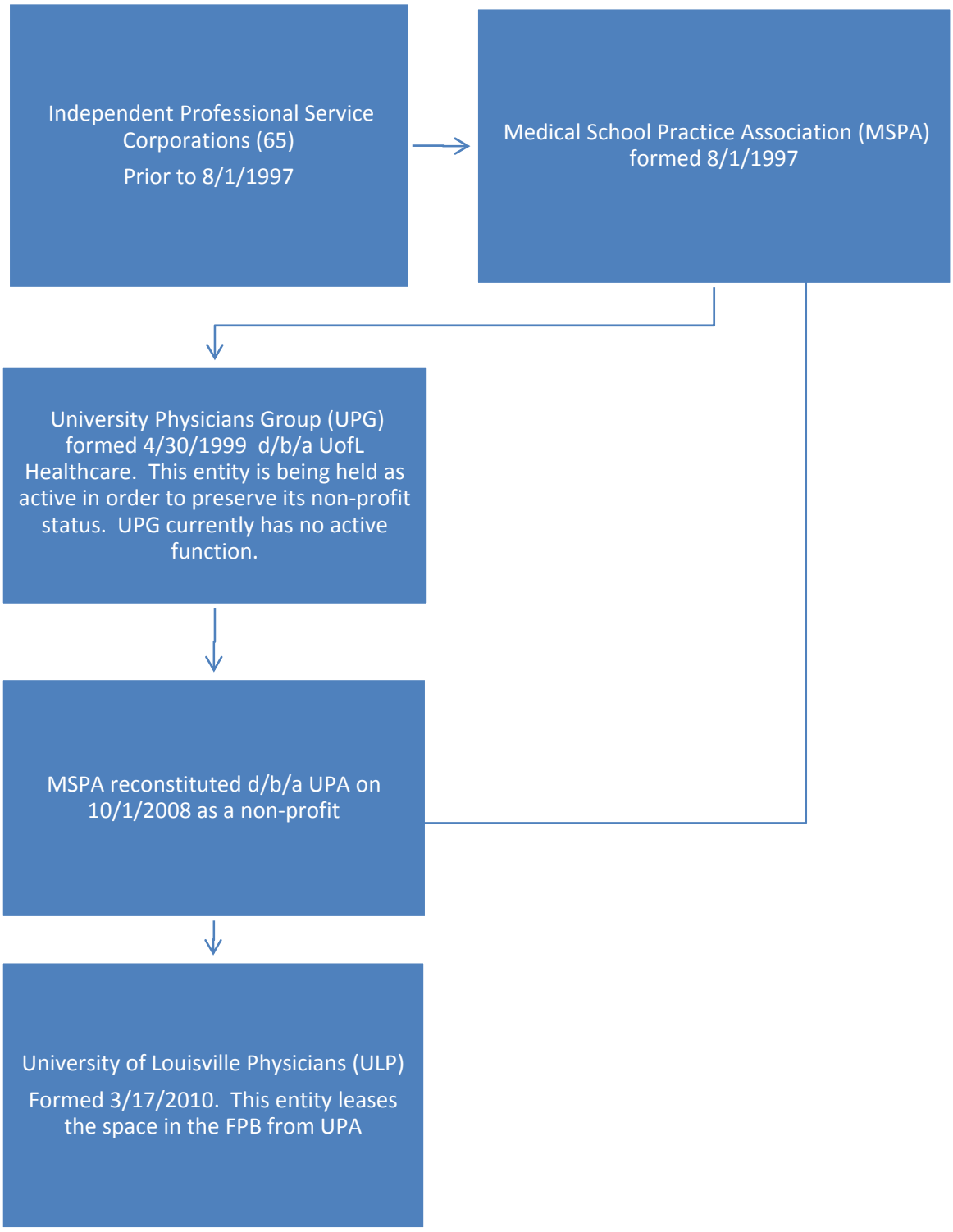
[2] We asked Dr. Postel to confirm our interview notes regarding the 15 year history of the transition from MSPA to ULP. Certain edits have been made to this discussion based on feedback received from Dr. Postel via counsel Baker Hostetler.

faculty. Instead, UPA assumed a greater role as a central point for the clinical faculty to undertake joint activities.

In 2010, faculty physicians determined that a single entity should be formed that would be the vehicle through which most clinical faculty of UofL School of Medicine would conduct their private clinical practice. As a result, University of Louisville Physicians (ULP) was incorporated as a Kentucky nonprofit corporation. It is anticipated that during 2012, clinical practices will transition to ULP so that ULP is the primary clinical vehicle for faculty physicians.

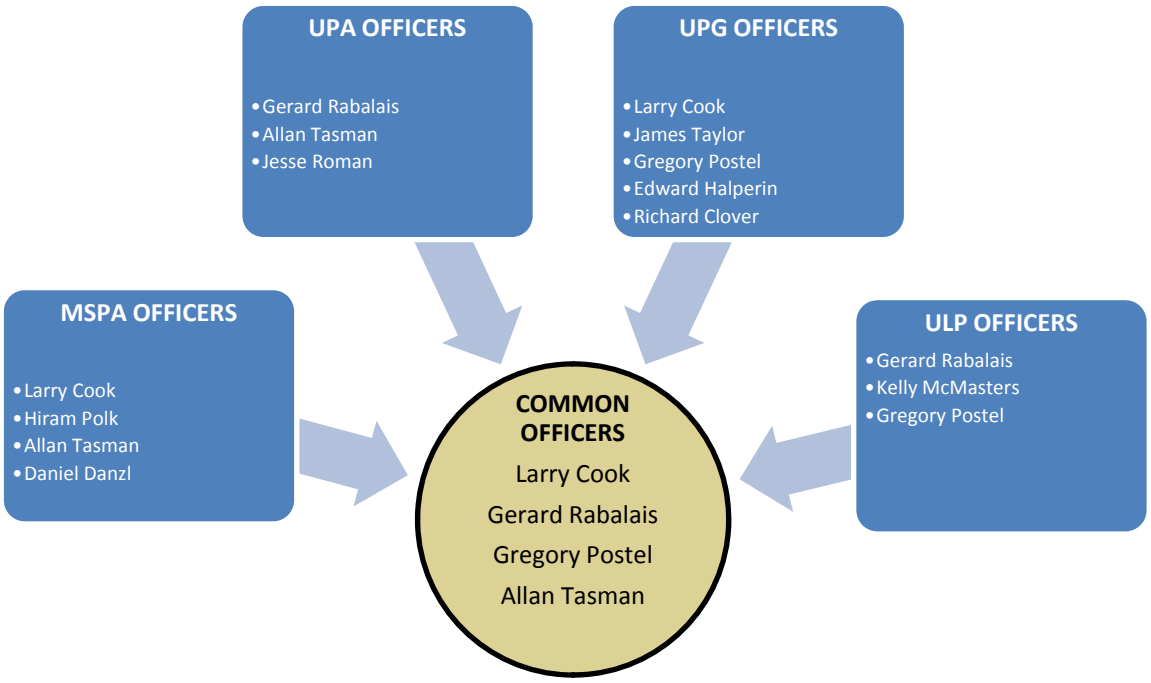
The timeline and Chart A-1 on the following page illustrate the evolution of the legal entities created or modified on behalf of certain UofL faculty physicians. As illustrated in Chart A-2, many of these entities had common officers and membership.

CHART A-1: TIMELINE OF EVENTS FOR MSPA, UPA, UPG and ULP[3]



[3] Kentucky Secretary of State. We noted dates on this webpage differed in some instances from the dates provided by UPA.

CHART A-2: Common Officers Between MSPA, UPA, UPG and ULP



General Information

The FPB is located at 401 Chestnut Street in Louisville, Kentucky on the campus of the University of Louisville (UofL). It opened in July 2008. The FPB has eight floors, seven above ground level and one below ground level with total square footage of approximately 170,000. Approximately 17 percent of the square footage is dedicated to common areas. Tenants consist of physician office space, an ambulatory surgery center, an imaging center, a rehabilitation center, a women's center, a retail pharmacy, and a conference center. A sky-bridge connects the FPB to a 1,200 car parking structure and a tunnel connects the FPB to University Medical Center.

Capital Projects and Bond Oversight Committee

The FPB was introduced to the KY Legislature Bond Oversight Committee on November 21, 2006[4]. Representative Mike Denham introduced Larry Owsley, Vice President for Business Affairs for UofL. Excerpts from the November 21, 2006, meeting minutes are included below. We have included this excerpt as "informational" only to convey certain background information about the initiative. *Please note that plans described therein may not reflect the actual final financing plan for the FPB.*

> *Mr. Owsley reported a long-term land lease for private development of a 170,000 SF clinical practice building on the UL Health Sciences Center campus. Mr. Owsley said that the UL Board of Trustees approved this lease at its September 2006 meeting, and it is being reported pursuant to the Committee's policy statement adopted in November 2002 regarding non-state development on state-owned property.*
>
> *Mr. Owsley said the University will lease 1.1 acres to a new entity called University/Faculty Office Building, LLC, to be owned 51 percent by Landmark Development Corporation, a faculty office/practice building entity, and 49 percent by University Physicians Group Inc. (UPG), a 501(c)(3) corporation set up to promote clinical operations at UL. This building will centralize operations of 461 clinical faculty who conduct private practices in facilities scattered throughout Louisville, Jefferson County, and Southern Indiana. Mr. Owsley said the facility will cost approximately $40 million to construct, and will be financed with $8 million in cash ($3.9 million paid by UPG and $4.1 million paid by* Landmark), and $32 million financed by Landmark Development Corporation.
>
> *Representative Wayne noted that a resolution issued by the UL Board of Trustees designated up to $10 million in health sciences resources for the project. He asked Mr. Owsley to clarify this source of funding. Mr. Owsley said a larger figure than necessary was used when this resolution was prepared. He said that $3.9 million in funding from the private practice groups would be designated for this project, and no University funds will be used.*

[4] Source KY Legislature Capital Projects and Bond Oversight Committee meeting minutes dated November 21, 2006.

Faculty Practice Building Developer

The developer that was selected to construct the FPB is commonly referred to as "Landmark." Landmark is comprised of two separate parallel corporations. Landmark Healthcare Facilities LLC and the Landmark Healthcare Properties Fund LLC are private limited liability companies that are registered with the State of Delaware.

Per the company's Web site http://landmarkfacilities.com/companies/ :

> Landmark Healthcare Facilities LLC is a … full-service developer of physician office buildings and clinics, ambulatory care and surgery centers, cardiac and cancer centers, imaging centers, fitness and women's centers and laboratories.
>
> Landmark [Healthcare] Facilities provides all the professional services and work product and deliverables that are required to design, develop, and construct the complete range of outpatient buildings, on a guaranteed-price, full-service basis. Landmark Facilities also serves as the property manager of all the outpatient buildings that are under the ownership of the Landmark Healthcare Properties Fund LLC.
>
> Landmark Healthcare Properties Fund, LLC was established to finance and own all the outpatient buildings the clients of Landmark Facilities do not want to own.
>
> As of April 30, 2011, the Landmark Fund owned 18 outpatient buildings in 11 states. These 18 outpatient buildings include approximately two million square feet in the aggregate. Based on current plans and estimates, four or five outpatient buildings will be added to the healthcare real estate portfolio of the Landmark Fund each year.

Landmark's Arrangement to Develop the FPB

Landmark Healthcare Properties Fund LLC (LHPF) is a holding company of approximately 19 single purpose limited liability corporations. One of the 19 single purpose limited liability corporations is the University Faculty Office Building LLC. Landmark Healthcare Properties Funds (LHPF) owns 51 percent of University Faculty Office Building LLC, the owning entity of the FPB.

The two related Landmark companies are family-owned private corporations. During a February 9, 2012, interview with Anthony Lampasona, President, we were informed that four members of the Checota family comprise 100 percent ownership of the companies. The percentage of ownership varies by individual. The chairman and chief executive officer is Joseph Checota. Nicholas Checota is the president and chief operating officer. The senior vice president of the two Landmark companies is Benjamin Checota.

Landmark's Arrangement with Groups Comprised of University Faculty Physicians

Based on the interview with Mr. Lampasona, and confirmed with UPA, we understand that Landmark was selected through a competitive bid process. In mid-2005, the University Physicians Group (UPG) doing business as University of Louisville Healthcare issued a request for proposals (RFP) for the development and construction of a new building to house outpatient and clinical services. Mr. Lampasona indicated that proposals from different firms were considered and Landmark Facilities received the award.

We attempted to corroborate the information provided by Mr. Lampasona by requesting from UPA a copy of the RFP and evaluation notes. UPA was unable to locate a copy of the RFP. However, UPA provided an October 2005 document entitled *Summary of Proposals* (TRG Healthcare, LLC), which describes proposals from three developers. Information received from Mr. Lampasona regarding the number of bidders (i.e., eleven) contradicted the evaluation summary provided by UPA, which describes three bidders. Based on the available information, we were unable to determine the true number of bidders. We were also unable to assess the financial terms, as would have been described in the original bidding opportunity. Of the three bids summarized within the document, the Landmark bid represented the median cost.

The tables below provide a summary of the project costs and financing terms, as described in the document *Summary of Proposals*. Although it is not clear how this document was used, or why it was prepared, the information contained therein is consistent with documents that would typically be used in a bid evaluation process. The document does not include a "recommendation" or a "conclusion" (i.e., decision) regarding a selected developer. We have included these excerpts as "informational" only to convey certain background information about the initiative. *Please note that the cost and financing information may not reflect the actual final project costs and financing plan.*

Project Cost and Financing*	REDINA	LANDMARK	TOWNSEND
Site Preparation, Construction & Fees	13,277,990	13,820,185	17,692,751
Tenant Improvement Allowance	5,192,552	5,465,950	4,836,000
General Contingency	490,708	988,600	1,511,580
Interest Reserve	738,750	514,593	1,880,022
Total Project Cost	$19,700,000	$20,789,328	$25,920,353
Construction Financing Rate	6.00%	5.50%	6.50%
Construction Financing Term	15 Months	18 Months	18 Months
Permanent Financing Rate	5.50%	6.25%	6.00%
% of Project Cost Financed	100%	80%	100%
Amortization Period	30 Years	30 Years	30 Years
Term	30 Years	10 Years	30 Years

*Source: University of Louisville Health Care Faculty Office Building *Summary of Proposals*, October 7, 2005, prepared by TRG Healthcare, LLC

Project Cost and Financing*	REDINA		LANDMARK		TOWNSEND	
	Cost	Cost/RSF	Cost	Cost/RSF	Cost	Cost/RSF
Building Shell	9,000,000	78.13	8,182,000	72.60	14,129,000	123.94
Site Costs	1,200,000	10.42	1,885,000	16.73	350,000	3.07
Tenant Improvement Allowance	5,167,552	44.86	5,465,950	48.50	4,836,000	42.42
Architectural and Engineering	720,000	6.25	1,049,010	9.31	1,187,500	10.42
Other Soft Costs	1,963,990	17.05	2,527,715	22.43	1,647,291	14.45
Loan Financing Fees	394,000	3.42	176,460	1.57	378,960	3.32
Interest Reserve	738,750	6.41	514,593	4.57	1,880,022	16.49
General Contingency	490,708	4.26	988,600	8.77	1,511,580	13.26
Total Cost	$19,700,000	$171.01	$20,789,328	$184.47	$25,920,353	$227.37

*Source: University of Louisville Health Care Faculty Office Building *Summary of Proposals*, October 7, 2005, prepared by TRG Healthcare, LLC

Landmark Healthcare Properties Fund (LHPF) currently has partial ownership in 19 single-purpose LLC's. Each of these single purpose LLC's serves as the ownership vehicle for a building constructed by Landmark Facilities. The entity that owns the Faculty Practice Building, University Faculty Office Building LLC (UFOB) is one of the 19 single purpose limited liability corporations held by LHPF. Mr. Lampasona indicated that the Faculty Practice Building is the only building in the Commonwealth of Kentucky in which Landmark currently has ownership.

UPA holds a 25-year master lease agreement with UFOB. Mr. Lampasona described the lease as a triple net operating lease in that the rent payments were calculated to be the equivalent of the debt service on the building for 25 years and the rent payments are made directly to the lender.

We asked Mr. Lampasona to identify the rate of return on Landmark's investment. We received the following reply from Mr. Lampasona: "As a private, family owned company, we do not disclose rate of return on investments."

The UofL Foundation appears to be the guarantor of the FPB, based on the *Notes to the [UofL] Consolidated Financial Statements for June 30, 2008 and 2007*[5]*.* Per Section 20c (Page 22):

> In December 2006, the Foundation became the guarantor of payments due to University Faculty Office Building, LLC (UFOB) under the Master Lease agreement between the Medical School Practice Association, Inc. (MSPA) and UFOB. The Foundation has guaranteed the full and prompt payment of all amounts due to UFOB including any damages for default and payments to reimburse UFOB for any costs and expenses incurred by UFOB to cure any default by MSPA. The initial lease term is 15 years, beginning in July 2008, the commencement date of the term of the lease. The annual lease payments due from MSPA to UFOB are approximately $3.5 million, with an annual inflation of 3 percent. The lease payments commenced in July 2008.[6]

At the end of the 25-year period, when the debt is completely repaid, ownership of UFOB will revert 100 percent to UPG.

In reviewing the notes to UPA's Consolidated Financial Statements for the years ended June 30, 2011 and 2010[7], we found a number of notes related to the University Faculty Office Building, LLC and Passport Health Plan. Certain Related Party Transactions between UPA and UofL are described in Note 10. In particular we noted the following:

- Of the funding received by UPA from UofL during the year ended June 30, 2011, $2,000,000 was provided through a grant agreement with the Executive Vice President for Health Affairs of the UofL on behalf of its School of Medicine and designated as support for the formation of an integrated faculty practice entity named University of Louisville Physicians, Inc.
- UPA reimburses UofL for various operating costs and for Passport funding received on behalf of certain medical clinics not operated by UPA. Total reimbursements payable were $774,049 and $1,318,209 at June 30, 2011 and 2010, respectively.

[5] 2008 Annual Report, Notes to Consolidated Financial Statements for June 30, 2008 and 2007, Section 20c, Page 22, Prepared by BKD, LLP, October 3, 2008, Independent Accountant's Report.
[6] There is a potential that this arrangement has been modified and/or terminated. We do not have access to UofL documents other than what can be found in the public domain. However, we have been unable to locate subsequent notes that contradict these statements.
[7] Consolidated Statements of Financial Position June 30, 2011 and 2010, Prepared by Dean Dorton Allen Ford, October 13, 2011, Independent Auditors' Report.

Mr. Lampsona described Landmark's involvement in the Faculty Practice Building as "limited" since the University of Louisville Physicians (ULP) assumed management of the building in January 2011. Prior to that time, Landmark provided personnel to oversee the daily property management functions. Mr. Lampasona was not able to provide information regarding the accounting and financial reporting for UFOB, but indicated that Landmark receives the appropriate annual tax reporting forms for its ownership interest in UFOB.

UPA Obtains Opinion on Rental Subsidy

In preparation for the proposed development of the FBP, UPA received a legal opinion from Hall Render Killian Heath & Lyman ("Hall Render") regarding the financial and logistical arrangements to develop the FBP. Excerpts from the September 24, 2008 Hall Render opinion letter to Eugene Gilchrist, Associate Vice President for Health Affairs are included below[8]:

> Pursuant to your request, we have examined whether any University Affiliate…. would jeopardize its tax exempt status by providing office space at a reduced rate to faculty physicians for use in the performance of charitable activities at the faculty office building. As we previously advised you…., we have concluded that no University Affiliate should be at risk of losing its tax exempt status, or in any other way violate the conditions of such status, due to the reduced rental rate because that reduced rental rate is intended to promote and allow the charitable activities that the faculty physicians perform at the building.
>
> …
>
> University of Louisville (the "University") is a Kentucky non-profit corporation that has been recognized by the Internal Revenue Service (the "IRS") as exempt from federal income taxation under Section 501 (c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). Affiliates of the University include University Physicians' Group, d/b/a University of Louisville Health Care ("ULHC"); University of Louisville Medical School Practice Association, Inc., d/b/a University Physicians Associates ("UPA"); and University of Louisville Foundation, Inc. (the "Foundation"), These affiliates, each of which is a Kentucky non-profit corporation that has been recognized by the IRS as exempt from federal income taxation under Code Section 50 1 (c)(3), shall be referred to collectively herein as the "University Affiliates."
>
> Landmark Healthcare Properties Fund, LLC ("Landmark"), is a Delaware series limited liability company unrelated to the University and the University Affiliates. Landmark and ULHC have jointly formed and will own and operate a development company named University Faculty Office Building LLC (the "LLC"). The LLC will construct, own, and manage a faculty office building (the "FOB"), which the LLC will master lease to UPA. UPA will sublease space in the FOB to several entities, including an imaging center, an ambulatory surgical center, and certain commercial

[8] This is an excerpt from the letter documents submitted by UPA which were previously marked "Privileged and Confidential Subject to Attorney-Client Privilege", requiring that Myers and Stauffer have an official or agent of UPA execute a waiver of such privilege. Under this formally granted waiver, Myers and Stauffer LC (MSLC) is authorized "to use references and excerpts in the letter in any report you [MSLC] prepare so long as you [MSLC] provide UPA with an opportunity to review and approve the use and accuracy of such excerpts." The submission and approval process for the excerpts used and noted herein was completed on April 30, 2012. No publication of this or any other extract from the above letter document is to be taken as legal advice for any person or entity.

retail tenants. …… UPA will also sublease space to for-profit medical practices formed as professional service corporations (the “PSCs") that are owned and operated by faculty physicians.

As part of the responsibilities of a physician appointed to the faculty of the University Medical School, faculty physicians must undertake certain education, research, administration, and community service activities, which are considered charitable in nature (the "Charitable Activities"). Upon completion of the FOB, the faculty physicians will engage in these activities within the space that they lease in the FOB. In fact, the subleases between the PSCs and UPA contain provisions which require that certain levels of Charitable Activities be performed in the FOB space. Failure to satisfy these requirements will result in termination of the sublease between UPA and the PSCs. Additionally, such physicians (either through their PSCs or otherwise) will perform professional medical services as part of their private medical practices ("Private Activities").

In establishing the prospective rent that UPA will charge the PSCs, consideration has been given to the balance between Charitable Activities and Private Activities. In effect, the PSCs will pay rent in proportion to the amount of Private Activities that they conduct in the FOB space. The remaining component of the rent (*i.e.,* the portion corresponding to the amount of Charitable Activities that the PSCs conduct in the FOB space) will be paid by the Foundation (or by another entity affiliated with the University). It is understood that space within the FOB will, to some extent, be used for Charitable Activities and Private Activities on an undivided basis. For example, a faculty physician might be teaching a resident physician at the same time that the faculty physician is seeing a patient with such physician's private practice. It is recognized that the faculty physicians do not segregate their Charitable and Private Activities on a moment-to-moment basis or among distinct work spaces.

For purposes of properly adjusting the rental rate to account for Charitable Activities that the faculty physicians will perform in the FOB, ULHC engaged the services of TRG Healthcare ("TRG") to estimate, on a monthly basis, the proportion of total time that individual faculty physicians will be engaging Charitable Activity.

The study required each faculty physician to estimate the amount of time in an average month that he or she will spend on Charitable Activities in the FOB. The study summarized the responses by three different methods, which were classified by TRG as (1) literal, (2) moderate, and (3) conservative. Because TRG ultimately determined that the literal summary likely overstated the Charitable Activities to be conducted in the FOB, the results were summarized by the moderate and conservative methods. Pursuant to the moderate summary, it was estimated that thirty-six percent (36) of the faculty physician's time at the FOB would be spent on Charitable Activities. By contrast, it was estimated under the conservative summary that twenty percent (20) of the faculty physician's time at the FOB would be spent on Charitable Activities.

TRG concluded that, "based upon the results of this study, there is no doubt that faculty members will be engaged in activities in the new FOB that will qualify as charitable activities."

To ensure that the rental adjustments accurately reflect the amount of time faculty physicians spend providing charity care at the FOB, TRG suggested that the study be performed again one (1) year after the faculty members have actually been practicing in the FOB, and that the study should be re-run every three (3) to five (5) years after that.

The study was needed to ensure that the faculty time spent in the FOB providing Charitable Activities is accurately reflected in the rental rate for the office space and, therefore, also assures the lease payment for space which will be used for clinical, for-profit activities reflects fair market value.

Follow-Up Charitable Activities Study

As described in the legal opinion from Hall Render Killian Heath & Lyman ("Hall Render") regarding the financial and logistical arrangements to develop the FBP, "TRG suggested that the [Charitable Activities] study be performed again one (1) year after the faculty members have actually been practicing in the FOB, and that the study should be re-run every three (3) to five (5) years after that."[9] Because it had been more than one year since the original study, we requested from UPA a copy of the follow-up Charitable Activities study.

UPA provided the document entitled *Results of Survey on Charitable Activities of Faculty in the Faculty Office Building (FOB)*, prepared by TRG Healthcare, LLC. The study described within the document was conducted similarly to the original study completed by TRG Healthcare, LLC. Excerpts from this document are included below.[10]

Results

The tool was given to all 224 faculty members who practice in the HCOC. The return rate for completed, valid surveys was 77% or 173 surveys completed. The percentages in each category indicate the proportion of time faculty members perform charitable activities in the [Health Care Outpatient Center] HCOC.

	Literal Summary	Conservative Summary
Results	49%	30%

[9] See Footnote 7.
[10] See Footnote 7.

Conclusions

TRG believes that based upon the results of this study, there is evidence to support that faculty members are engaged in activities in the HCOC that qualify as charitable activities. Using the most conservative calculation method, the study indicates that 30% of faculty time spent in the HCOC is spent engaged in charitable activities.

TRG Recommendations

1. The conservative calculation should be used for planning and policy purposes. This would be the easiest option to support on an on-going basis.

2. Charitable clinical activities should also be factored into this study. Each department Business Unit Manager should provide their payer mix broken out by payer in order to determine how much clinical care is considered charitable. Clinical time would be the difference between the total time spent in the HCOC less the amount of time estimated for charitable activities in teaching, administration, research and community activities. The calculation of charitable clinical time would be the percent of uninsured and a factor for underinsured patients divided by the total patients then multiplied by clinical time.

Tenant and Rent Information

During a tour of the FPB on January 18, 2012, we met with Michael Mitchell and Ralph Hall of ULP. Mr. Mitchell and Mr. Hall process the leases for the FPB in conjunction with a law firm consultant. They stated that most tenant subleases are 10 years, with the exception of the UofL leases, which are typically two years in duration.

Subsequent to the interviews with Dr. Postel and Michael Mitchell, we submitted a data request to both individuals on January 30, 2012, with a requested submission date of February 3, 2012. The requests included the rental rates paid by each tenant and the master lease agreement between UPA and the UFOB. On February 22, 2012, we received a copy of the master lease, the amendment to the master lease and a table summarizing the rent per square foot per tenant. The key items from those documents are included below.

- **Base Rent:** [Amount] per rentable square foot per year for the first year of the Initial Term and adjusted every year thereafter by a sum equal to the Base Rent

for the year prior multiplied by three percent. The rent shall be increased on each anniversary date of the Commencement Date. Base Rent for the first year of the Initial Term is estimated to be $3.49 million, per year, payable in equal monthly installments of $290,955

  - Amendment Section 1.9-Base Rent was changed to include a schedule of rents for the new 25 year term. The schedule indicates an annual increase of approximately three percent for the entire term of the lease.

- **Landlord's Services:** The Landlord is responsible to provide electricity, hot and cold water, heating, ventilation and air conditioning, janitorial and other services to maintain the Building. The cost of these services is passed on to the tenants pursuant to subleases.[11]

- **Tenant Guarantor:** University of Louisville Foundation

- **Exhibit G Section 1.4:** States the Landlord will pay an amount not more the $52.00 per square foot for Tenant Improvements.

  - Amendment changed the Tenant Improvement limit from $52.00 per square foot to $83.28 per square foot.

The following table details the rentable square footage (RSF) as of June 22, 2009 and rental rates for each tenant space:

[11] These statements reflect subsequent clarification from UPA.

STE#	Tenant	RSF	Start Date	Base Rent 1st Yr	Base Rent 2nd Yr	% Δ	Base Rent 3rd Yr	% Δ	Base Rent 4th Year	% Δ
L10	UMC, Inc.	23,128	9/1/08	$ 38.71	$ 39.87	3%	$ 41.07	3%	$ 42.30	3%
110	UofL-Student Health	3,086	7/1/08	$ 13.73	$ 13.73	0%	$ 14.46	5%	$ 14.46	0%
130	Vacant	3,147		$ -	$ -	0%	$ -	0%	$ -	0%
170	Calistoga	4,985	1/10/09	$ -	$ 25.00	0%	$ 25.75	3%	$ 26.52	3%
180	UMC, Inc.	2,618	7/1/08	$ 21.78	$ 22.43	3%	$ 23.11	3%	$ 23.80	3%
210	UMC, Inc.	9,260	9/1/08	$ 38.58	$ 39.74	3%	$ 40.93	3%	$ 42.16	3%
240	Orthopedic Trauma Assoc	1,100	8/1/09	$ -	$ 12.00	0%	$ 12.36	3%	$ 12.73	3%
270	UMC, Inc.	7,987	7/1/08	$ 23.02	$ 23.71	3%	$ 24.42	3%	$ 25.15	3%
310	UMA, PSC	13,344	7/1/08	$ 13.32	$ 13.72	3%	$ 14.13	3%	$ 14.56	3%
370	UPA, Inc.	4,428	8/1/08	$ 13.75	$ 14.16	3%	$ 14.59	3%	$ 15.02	3%
380	UMC, Inc.	1,591	8/1/08	$ 25.72	$ 26.49	3%	$ 27.29	3%	$ 28.10	3%
410	Univ. OBGYN Assoc.	17,554	9/1/08	$ 16.45	$ 16.94	3%	$ 17.45	3%	$ 17.98	3%
460	UofL Continence Ctr	2,944	9/1/08	$ 14.57	$ 15.01	3%	$ 15.46	3%	$ 15.92	3%
480	University Urology	3,145	9/1/08	$ 14.35	$ 14.78	3%	$ 15.22	3%	$ 15.68	3%
510	University Neurologists	12,792	7/1/08	$ 12.82	$ 13.20	3%	$ 13.60	3%	$ 14.01	3%
550	U of L School of Dentistry	8,622	9/1/08	$ 16.30	$ 16.30	0%	$ 17.14	5%	$ 17.14	0%
560	UPA, Inc.	1,049	7/1/08	$ 21.00	$ 21.63	3%	$ 22.28	3%	$ 22.95	3%
580	University Neurosurgery	1,175	5/5/09	$ -	$ 12.83	0%	$ 13.21	3%	$ -	0%
610	University Psychiatric	14,331	7/1/08	$ 12.00	$ 12.36	3%	$ 12.73	3%	$ 13.11	3%
620	Republic Bank & Trust	445	9/1/09	$ -	$ 20.55	0%	$ 21.17	3%	$ 21.80	3%
660	Vacant	2,760		$ -	$ -	0%	$ -	0%	$ -	0%
670	UMC, Inc.	2,716	9/1/08	$ 30.15	$ 31.05	3%	$ 31.99	3%	$ 32.95	3%
690	UMA, PSC	3,246	8/1/08	$ 13.99	$ 14.41	3%	$ 14.84	3%	$ 15.29	3%
710	University Surgical Assoc	24,179	8/1/08	$ 12.28	$ 12.65	3%	$ 13.03	3%	$ 13.42	3%

Note 9 of UPA's Consolidated Financial Statements for the years ended June 30, 2011 and 2010, related to Operating Leases, describes the master lease of the medical office building between UPA and University Faculty Office Building, LLC. It also describes the sublease of space in that same building to various private medical practices of UofL faculty members and the University Medical Center, Inc. The note includes two tables that illustrate the approximate minimum future rental payments for the master lease which extends through 2034 and the subleases which expire at various dates.

According to Note 9, for the years ending June 30, 2012 through 2016, UPA will pay, on average, approximately $754,000 per year more for rental payments due under the master lease than rental payments collected under the sublease agreements. UPA considers this amount as a charitable contribution to the private medical practices of the UofL faculty members and to the University Medical Center, Inc.

Additional Information

We identified certain additional relevant information on a website http://genegilchrist.com/?page_id=18. From this website on February 17, 2012, we understand that Mr. Gilchrist may be a former employee of the UofL and that he "served as the part-time Chief Executive Officer for University Physicians Associates." On this website, Mr. Gilchrist describes the rental rates for the Faculty Practice Building:

> ***University of Louisville Health Care Outpatient Center***
>
> *This project involved the use of a developer to create a 193,000 square foot, outpatient center completely staffed by University physician practice and the University Hospital. This project was managed almost completely by me from identifying developer partners to managing the opening events. The facility, opened in July 2008, remains the signature outpatient facility in Louisville with a 29,000 square foot Ambulatory Surgery Center, 12,000 square foot imaging center, 450 adjacent parking spaces exclusively for patients, and the full array of adult services. University of Louisville Health Sciences Center formed a for-profit corporation with the developer. That member organization subsequently signed a ground lease with the University and a Master Lease with the cooperative, physician organization. Faculty practice lessees have the benefits of ownership passed through the master lease at rates well below market, and ownership of the facility passes to the University in twenty-five years.*

Please note that we did not attempt to speak with Mr. Gilchrist about the information contained on his website.

Based on an independent inquiry of office space in buildings comparable to the FPB, we understand that the Louisville Kentucky market would require rental rates in the range between $12.50 and $35 per square foot with an average of approximately $27.38 per square foot. Variables that impact the rental rates include the amount of space required, the class of building, and its location, among others.

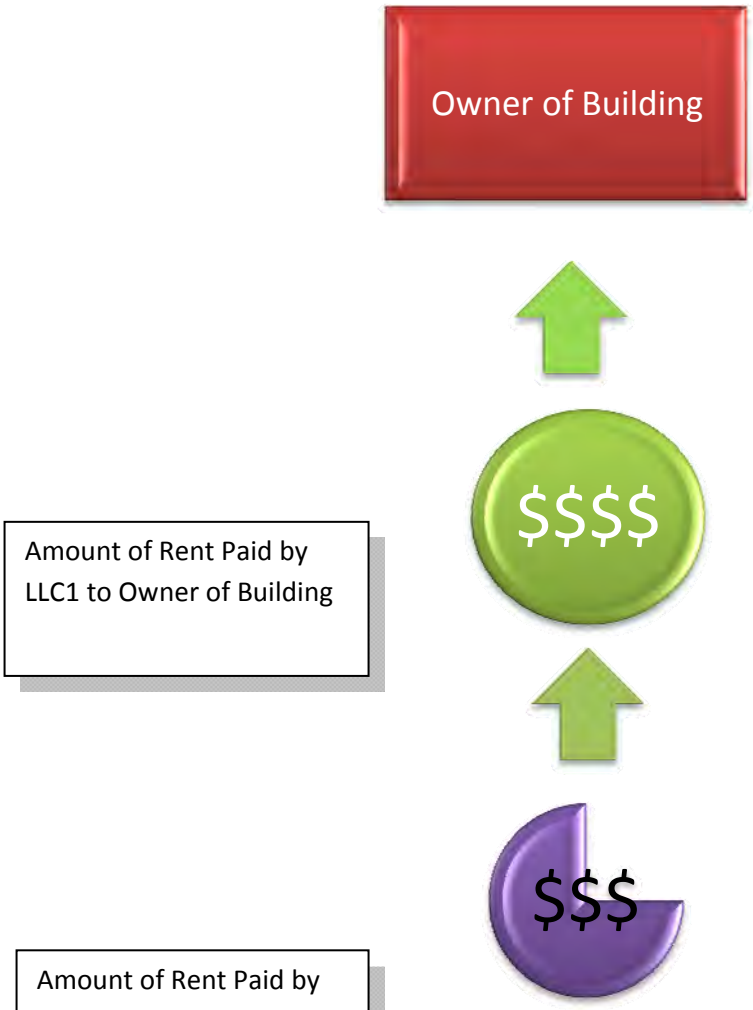
Another potential component affecting the rental rates is the use of a rate reduction associated with the charitable use of the space. The sublease included in the master lease contains a provision (Section 1.8(b) of Exhibit K in the master lease) which

acknowledges the requirement that UofL physicians provide charitable, educational and research duties.

The graph on the following pages provides an example (using fictitious data) of how a charitable use rental reduction could be reflected in the cash flow of a lease.

Example of a Common Arrangement

In this example, a responsible entity subleases office space with a charitable use reduction component. The owner of the building has a master lease with LLC1 which calls for a fixed rental payment usually made on a monthly basis. LLC1 subleases the building to various tenants (LLC2) whose rental payments include a reduction for the amount of charity use of the rental space. In this illustration, the tenant has a 25 percent reduction to the rental payment for charitable use.


Owner of Building
$$$$
Amount of Rent Paid by LLC1 to Owner of Building
$$$
Amount of Rent Paid by LLC2 to LLC1

√ Observations, Findings or Recommendations Related to the University Faculty Practice Office Building

1) The average base rent for space occupied by University Medical Center (UMC), Inc is $32.41 per square foot whereas the base rent for *all other* spaces was $16.71 per square foot.

   The differential between the highest and lowest rates spanned from $26.71 to $29.57 over the four base years. Summary statistics for the four years of rental rates are as follows:

FPB Rent Per Square Foot	Year 1	Year 2	Year 3	Year 4
Minimum	$12.00	$12.00	$12.36	$12.73
Maximum	$38.71	$39.87	$41.07	$42.30
Median	$15.44	$15.66	$16.30	$17.14
Average	$19.58	$19.66	$20.28	$21.19

   Based on a non-scientific review of available similarly rated spaces, the rental rates paid by tenants in the FPB are similar to those in the Louisville, Kentucky market.

2) There is a provision contained in the Master Lease that indicates a three percent inflationary adjustment will be applied to the base rent. However, based on the information provided, the inflationary adjustment is not universally applied.

3) We have not identified conditions, terms of use, restrictions, or other prohibitions (collectively referenced as “Conditions”) placed on payments received for eligible services provided or costs eligible for reimbursement from Medicaid via the fiscal agent contractor, or those administered by Passport, other than as described in federal statutes or regulations, or Revised Statutes or Administrative Regulation of the Commonwealth of Kentucky, although this does not constitute a legal opinion.

4) Although we were informed that the debt service is paid through leases based on triple net pricing, the Master Lease suggests that another arrangement may be used instead. The lease indicates that the Landlord is responsible for the operational and maintenance costs of the building. It is unclear whether there are other agreements that may exist among the entities that provide additional information regarding revenue and cost arrangements. We were informed by

UPA that the Landlord costs for operations and maintenance are computed into the sublease arrangements.

5) Public records searches ordered by Myers and Stauffer found nothing to dispute any of the information on the Landmark companies' Web page, or in the information provided by Mr. Lampasona. Furthermore, Mr. Lampasona stated that there is no relationship or common ownership between Landmark or any entity other than the Checota family, including any physician or physician group at the UofL.

6) UPA was unable to locate certain documents relating to the request for proposal, the evaluations, and the scoring sheets for the bidder proposals received for the development of the FPB. They provided a summary of proposals, which included an overview of three bids. During the interview of Mr. Lampasona (Landmark), he indicated that he believed there were eleven bids. We requested that he attempt to locate documents to confirm his recollection. He was unable to locate other documents. We requested that UPA attempt to locate documents related to the bid. They indicated that they could not locate materials other than the aforementioned summary. Because these documents could not be located, we could not confirm that the final financial arrangements to develop the FPB were consistent with the terms and conditions as included in the original RFP.

7) Although it was stated in the KY Legislature Capital Projects and Bond Oversight Committee meeting minutes dated November 21, 2006, that no university funds would be used on the FPB, it appears that university funding was used for the initiative. Based on meeting minutes from the UofL Foundation Board of Directors meeting on September 28, 2006, it appears that the EVPHA may have contributed to the construction of the Faculty Practice Building.

> "Dr. Cook reported the sources of financing:
> - UPA
> - Executive Vice President for Health Affairs
> - University Hospital
> - PSCs
> - Ambulatory Surgery Center
> - Imaging LLC
> - Landmark Healthcare Facilities"

Funds received for services performed at the UofL Primary Care Centers (i.e., UPA) may include Safety-net funding, which is described elsewhere in this report. Funds received by the Executive Vice President for Health Affairs may include Medical Education funds, which are described elsewhere in this report.

It is important to note that we have not been engaged to opine on the permissibility of funding from any source, including those from the University. It

should also be noted that the arrangements described during the Bond Oversight Committee meeting may not reflect the actual final financing plan for the FPB.

8) Because of the complexities involved in the transactions, including the financing and operations of the FPB, and the relationships among entities (i.e., the university and its faculty physicians), we recommend that the University Audit Services group thoroughly evaluate the funding sources, the transactions, relationships, and operational aspects of the FPB.

Contract Reference	Page #	SFY 2011 Contract Language	SFY 2010	SFY 2009
		Definitions		
Definition	1 to 11	**Subcontract** means any agreement entered into, directly or indirectly, by Contractor, in compliance with the provisions of Section 1.7 of this Contract, for purposes of fulfilling any of Contractor's obligations under this Contract or the Partnership Program including, but not limited to, any arrangements for the provision of any administrative, support or health care services, or to provide any material to support provision of such services. However, except as may be required under Section 3.2.3 of this Contract, the term "Subcontract" does not include a policy of insurance or reinsurance purchased by the Contractor or a Subcontractor to limit its specific or aggregate loss with respect to Covered Services provided to Members hereunder provided the Contractor or its risk-assuming Subcontractor assumes some portion of the underwriting risk for providing health care services to Members.		
Definition	1 to 11	**Subcontractor** means any person or entity which contracts directly or indirectly, or otherwise agrees, to perform any function, or to support performance of any function, for the purpose of fulfilling Contractor's obligations under this Contract or the Partnership Program including, but not limited to, provision of any administrative, support, or health care services, or to provide any material in support of those services.		
		Subcontracts		
1.7.2	19	**Requirements**		
		The Contractor may, with the approval of the Department, enter into Subcontracts for the performance of its administrative functions or the provision of various Covered Services to Members. All Subcontractors must be eligible for participation in the Medicaid program as applicable. The Contractor shall submit for review to the Department each subcontract or contract prior to signing. The Department may approve, approve with modification, or deny subcontracts under this contract with cause if the subcontract does not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a subcontract, the Department may consider such factors as it deems appropriate to protect the State and Members, including but not limited to, the proposed subcontractor's past performance. Each Subcontract, and any amendment to an approved Subcontract, shall be in writing, and in form and content approved by the Department.		
		In the event Contractor has not reached an agreement with Subcontractor within the applicable time frame, Contractor shall notify the Department and keep the Department informed of the status of the negotiations until the applicable contract is finalized. In the event the Department has not approved the subcontract prior to the scheduled effective date, Contractor agrees to execute said subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontract within ten (10) days following termination.		
		The Department's subcontract review shall assure that all Subcontracts:		
		(a) Identify the population covered by the Subcontract;		
		(b) Specify the amount, duration and scope of services to be provided by the Subcontractor;		
		(c) Specify procedures and criteria for extension, renegotiation and termination;		
		(d) Specify that Subcontractors use only Medicaid providers in accordance with this Contract;		
		(e) Make full disclosure of the method and amount of compensation or other consideration to be received from the Contractor;		
		(f) Provide for monitoring by the Contractor of the quality of services rendered to Members, in accordance with the terms of this Contract;		
		(g) Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;		
		(h) Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;		
		(i) Contain an explicit provision that the Department is the intended third-party beneficiary of the Subcontract and, as such, the Department is entitled to all remedies entitled to third-party beneficiaries under law;		
		(j) Specify that Subcontractor agrees to submit Encounter Records in the format specified by the Department so that the Contractor can meet the Department's specifications required by this Contract;		
		(k) Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including without limitation, the obligation to comply with all applicable federal and Commonwealth law and regulations, including but not limited to, KRS 205.8451-8483, all rules, policies and procedures of the Department, and all standards governing the provision of Covered Services and information to Members, all QAPI requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of the Department, the Office of the Inspector General, the Attorney General and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations, all indemnification and insurance requirements, and all obligations upon termination;		
		(l) Provide for Contractor to monitor the Subcontractor's performance on an ongoing basis, including those with accreditation: the frequency and method of reporting to the Contractor; the process by which the Contractor evaluates the subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually.		
		(m) A subcontractor with NCQA accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.		
		(n) Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.		
		(o) The remedies up to, and including, revocation of the subcontract available to the Contractor if the subcontractor does not fulfill its obligations.		
		(p) Contain provisions that suspected fraud and abuse be reported to the contractor.		
1.7.3	21	**Disclosure of Subcontractors**		
		The Contractor shall inform the Department of any Subcontractor which engages another Subcontractor in any transaction or series of transactions, in performance of any term of this Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense.		
1.7.5	21	**Physician Compensation Plans**		
		Any compensation arrangement between the Contractor and a physician, or physician group as that term is defined in 42 C.F.R. § 417.479(c), or between the Contractor and any other Primary Care Providers within the meaning of this Contract, or between the Contractor and any other Subcontractor or entity that may directly or indirectly have the effect of reducing or limiting services provided to Members must be submitted to the Department for approval prior to its implementation. Approval is preconditioned on compliance with all applicable federal and Commonwealth laws and regulations. The Contractor must provide information about any Physician Incentive Plan to any Member upon request.		
1.10	22	**Contractor Attestation**		
		The Chief Executive Officer (CEO), the Chief Financial Officer (CFO) or Designee must attest to the best of their knowledge to the truthfulness, accuracy, and completeness of all data submitted to the Department at the time of submission. This includes encounter data or any other data in which the contractor paid claims.		

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		Organization		
2.0	22	The Contractor shall meet the requirements of the organization as defined in 907 KAR 1:705 to be eligible as a Contractor under the requirements of the Partnership Program including the following:		
		(a) Have at least one teaching hospital in the Partnership Program if one is located in the Partnership Region;		
		(b) Have broad representation of provider types on the Council's Board;		
		(c) Have consumer representation in planning and on the Council's Board;		
		(d) Have a network of providers (which includes each of the following provider types: hospitals, home health, dentists, vision, hospice, pharmacy, prevention, primary care, and maternity care providers);		
		(e) Have a provider network representing the complete array of provider types including primary care providers, primary care centers, federally qualified health centers and rural health clinics, local health departments and the Kentucky Commission for Children with Special Health Care Needs; and		
		(f) Be licensed or contain an entity that is licensed as a health maintenance organization or provider-sponsored integrated health delivery program in the Commonwealth.		
		Administration / Staffing		
2.1	23	The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the services provided by the Partnership Program. Responsibility for these functions or staff positions may be combined or split among departments, people or Subcontractors.		
		(a) The **Executive Management** shall be capable and responsible for the oversight of the entire operation of the Partnership Program.		
		(b) A **Medical Director** who shall be a Kentucky-licensed physician. The Medical Director shall be actively involved in all major clinical programs and Quality Improvement components of the Partnership Program. The Medical Director shall devote sufficient time to the Partnership Program to ensure timely medical decisions, including after-hours consultation as needed.		
		(c) A **Dental Director** who shall be a dentist licensed by a Dental Board of Licensure in any state. The Dental Director shall be actively involved in all major dental programs of the Partnership Program. The Dental Director shall devote sufficient time to the Partnership Program to ensure timely dental decisions, including after-hours consultation as needed.		
		(d) A **Finance function and Officer** or designee**,** to oversee the budget and accounting systems implemented by the Contractor.		
		(e) A **Member Services function** to coordinate communications with Members and act as Member advocates. There shall be sufficient Member Services staff to enable Members to receive prompt resolution to their problems or inquiries.		
		(f) A **Provider Services function** to coordinate communications between the Contractor and its Subcontractors. There shall be sufficient Provider Services staff to enable Providers to receive prompt resolution to their problems or inquiries. The Provider Services function shall include oversight of the Subcontractors.		
		(g) A **Quality Improvement Director** who shall be responsible for the operation of the QAPI Program.		
		(h) A **Behavioral Health Liaison** who shall be responsible for coordination between the Contractor and Providers who render Behavioral Health Services to Members.		
		(i) A **Case Management Coordinator** who shall be responsible for overseeing Case Management Services and continuity of care for all Members.		
		(j) An **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) coordinator** who shall be responsible for the provision of EPSDT services within the Partnership Program.		
		(k) A **Foster Care/Subsidized Adoption Liaison** who shall serve as the Contractor's primary liaison for meeting the needs of foster care and subsidized adoptive children.		
		(l) A **Guardianship Liaison** who shall serve as the Contractor's primary liaison for meeting the needs of adult guardianship clients.		
		(m) A **Management Information System function** which shall be responsible for the management and maintenance of a management information system (MIS).		
		(n) A **Claims processing function** to ensure the timely and accurate processing of original claims, corrected claims, re-submissions and overall adjudication of claims.		
		(o) A **Program Integrity Coordinator** who shall be responsible for the function of managing the program integrity unit of the Contractor.		
		(p) A **Pharmacy Coordinator** who shall be responsible for the oversight of pharmaceutical services and benefits within the Partnership Program.		
	24	The Contractor will designate a staff person to act as liaison to the Department for all issues that relates to the Contract between the Department and the Contractor. The Contractor's representative shall act as the primary contact and will be authorized to represent the Contractor regarding inquiries pertaining to the contract, will be available during normal business hours, and will have decision-making authority in regard to urgent situations that arise. The contract representative will be responsible for follow-up on contract inquiries initiated by the Department.		
		The Contractor shall submit to the Department any material changes to the current organizational chart, and upon request by the Department, an updated organizational chart depicting all functions including mandatory ones, number of employees in each functional department, and key managers responsible for the functions. The Contractor shall notify the Department in writing of any staffing change in the Executive Management, Medical Director or Quality Improvement Director positions within 10 business days. The Contractor shall ensure that all staff, Providers and Subcontractors have appropriate training, education, experience, liability coverage and orientation to fulfill the requirements of their positions.		
		Contractor shall provide notice to the Department of any changes relating to the personnel of its administrator's management staff, including a change in duties or time commitments. Contractor shall assure the adequacy of its administrator's staffing to properly service the needs of Contractor if changes are proposed in the personnel, duties or time commitments of administrator's staff from those in place on the Effective Date of each Contract. Contractor shall provide those assurances to the Department before permitting its administrator to implement such changes.		
		Financial Information		
3.1.5		**Payment Adjustments**		
		Monthly Capitation Payments will be adjusted to reflect corrections to the Member Listing Report, provided the corrections are received within forty-five (45) days of receipt of the Member Listing Report. Payments will be adjusted to reflect the automatic enrollment of eligible newborn infants pursuant to Section 7.3.1.1. Claims for payment adjustments shall be deemed to have been waived by the Contractor if a payment request is not submitted in writing within six months following the month for which an adjustment is requested. Waiver of a claim for payment shall not relieve the Contractor of its obligations to provide Covered Services pursuant to this Contract.		
		In the event that a Member is eligible and enrolled in the Partnership Program but does not appear on the Member Listing Report, the Contractor may submit a payment adjustment request. Each request must contain the following Member information:		
		(a) Name (last, first, middle initial) and Medicaid identification number;		
		(b) Current address;		
		(c) Age and aid category; and		
		(d) Month for which payment is being requested.		
3.1.12	29	**Advances, Distributions and Loans**		

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		The Contractor shall not, without thirty (30) days prior written notice to the Department, make any advances to a related party or Subcontractor. The Contractor shall not, without similar thirty (30) day prior written notice, make any distribution, loan or loan guarantee to any entity, including another fund or line of business within its organization. Written notice is to be submitted to the Department's Contract Compliance Officer. The prohibition on advances to Subcontractors contained in this subsection shall not apply to Capitation Payments or payments made by the Contractor to Contractor's Network or UHC.		
3.1.14	30	**Provider Risks**		
		If a Provider assumes substantial financial risk for services not provided by the Provider, the Contractor must ensure that the Provider has adequate stop-loss protection and must conduct annual Member surveys. The Contractor must provide the Department proof the Provider has adequate stop-loss coverage, including an amount and type of stop-loss.		
3.3	30	**Stop Loss Program**		
		The Department may choose to offer the Contractor the option of participating in a Stop-Loss Program. A Stop-Loss Program is intended to insulate the Contractor against unforeseen or unmanageable large claims risk. The specific Stop-Loss program is in the Department's sole discretion as specified in 907 KAR 1:705, Section 6, Subsection 3. The Contractor may elect to purchase Stop-Loss insurance from a private reinsurer.		
3.4	30	**Provider Claims Payments**		
		In accordance with the Balanced Budget Act (BBA) Section 4708, the Contractor shall implement claims payment procedures that ensure 90% of all provider claims are paid or denied within thirty (30) days of the date of receipt of such claims and that 99% of all claims are processed within ninety (90) days of the date of receipt of such claims following the date of such claims, properly documented and sufficient for processing, are submitted. In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended.		
		The Contractor must at least, notify the requesting provider of any decision to deny a Claim, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.		
		Any conflict between the BBA and Commonwealth law will default to the BBA unless the Commonwealth requirements are stricter.		
3.5	31	**Payment to Out of Network Providers**		
		The Contractor shall reimburse Out of Network Providers in accordance with Section 3.4 for the following Covered Services:		
		(a) Specialty care for which the Contractor has approved a authorization for the Member to receive services from an Out of Network Provider;		
		(b) Emergency Care that could not be provided by the Contractor's Network Provider because the time to reach the Contractor's Network Provider capable of providing such services would have meant risk of serious damage to the Member's health; and		
		(c) Foster children.		
3.6	31	**Payment to Providers for Serving Dual Eligible Members**		
		The Contractor shall coordinate benefits for Dual Eligible Members by paying the lesser amount of (1) Contractor's allowed amount minus the Medicare payment, or (2) the Medicare co-insurance and deductible up to Passport's allowed amount. The Contractor shall further assist Dual Eligible Members in coordination of benefits in furtherance of the requirements under Section 3.3.		
3.7	31	**Payment to Federally Qualified Health Centers ("FQHC") and Rural Health Clinics ("RHC")**		
		The Contractor shall pay FQHC(s) and RHC(s) in the Contractor's Network by using the methodology in the currently approved CMS waiver. Any modifications to the payment method shall be submitted to the Department for review and approval prior to implementation.		
		The Contractor shall assure that payment for services provided to FQHCs and RHCs is paid in accordance with the waiver and shall not be less than the level and amount of payment the Contractor would make for the services if the services were furnished by other clinic or primary care Providers.		
3.8	31	**Payment to Teaching Hospitals**		
		In establishing payments for teaching hospitals in its Contractor's Network, the Contractor shall recognize costs for graduate medical education, including adjustments required by KRS 205.565.		
3.9	31	**Coordination of Benefits (COB)**		
		The Contractor shall actively pursue, collect and retain all monies available from all available resources for services to Members under this Contract except where the amount of reimbursement the Contractor can reasonably expect to receive is less than estimated cost of recovery.		
		Cost effectiveness of recovery is determined by, but not limited to, time, effort, and capital outlay required in performing the activity. The Contractor, upon request by the Department, shall specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party, or describe the process by which the Contractor determines seeking reimbursement would not be cost effective.		
		COB collections are the responsibility of the Contractor or its Subcontractors. Subcontractors must report COB information to the Contractor. Contractor and Subcontractors shall not pursue collection from the Member but directly from the third party payer or the provider. Access to Covered Services shall not be restricted due to COB collection.		
		The Contractor shall maintain records of all COB collections. The Contractor must be able to demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. The Department has the right to review all billing histories and other data related to COB activities for Members. The Contractor shall seek information on other available resources from all Members.		
		In order to comply with CMS reporting requirements, the Contractor shall submit a monthly COB Report from the entire service area. Additionally, Contractor shall submit a report that includes subrogation collections from auto, homeowners, or malpractice insurance, etc.		
		Management Information System		
4.	32	The Contractor will be required to maintain a Management Information System (MIS) that will provide support for all aspects of a managed care operation to include the following subsystems: recipient, third party liability, provider, reference, encounter/claims processing, financial and utilization data /quality improvement. The Contractor will also be required to demonstrate sufficient analysis and interface capacities. The Contractor's MIS must be able to assure medical information will be kept confidential through security protocol, especially as that information relates to personal identifiers and sensitive services.		
		The Contractor shall provide such information in accordance with the format and file specifications for all data elements as specified in Attachments hereto.		
		The Contractor shall notify the Department of all significant changes to the system that may impact the integrity of the data, including such changes as new claims processing software, new claims processing vendors and significant changes in personnel.		

Contract Reference	Page #	SFY 2011 Contract Language	SFY 2010	SFY 2009
4.1	32	**Contractor MIS Requirements**		
		At a minimum, Contractor is required to maintain and operate a MIS that has the capacity to capture the data specified below and provide the Department with reports in formats and files that are consistent with the Department's functional subsystems, which may include, but is not limited to, the following:		
		(a) Recipient Subsystem		
		(b) Third Party Liability (TPL)		
		(c) Provider Subsystem		
		(d) Reference Subsystem		
		(e) Encounter/Claims Processing Subsystem		
		(f) Financial Subsystem		
		(g) Utilization/Quality Improvement Subsystem		
		The Contractor is not required to have actual subsystems as listed above, provided the requirements are met in other ways which may be mapped to the subsystem concept. The Contractor must maintain flexibility to accommodate the Department's need if a new system is implemented by the state.		
		The Contractor shall ensure that data received from Providers and Subcontractors is accurate and complete by:		
		(a) Verifying, through edits and audits, the accuracy and timeliness of reported data;		
		(b) Screening the data for completeness, logic and consistency;		
		(c) Collecting service information in standardized formats to the extent feasible and appropriate; and		
		(d) Compiling and storing all claims and encounter data from the Subcontractors in a data warehouse in a central location in the Contractor's MIS.	Not included	Not included
4.1.1	33	**Recipient Subsystem**		
		The primary purpose of the recipient subsystem is to accept and maintain an accurate, current, and historical source of demographic information on Recipients to be enrolled with the Partnership Program.		
		The maintenance of enrollment/member data is required to support claims and encounter processing, third party liability (TPL) processing and reporting functions. The major source of enrollment/member data will be electronically transmitted by DMS to the Contractor on a daily basis. A monthly file of Members will be electronically transmitted to the Contractor by Thursday before the last Friday of each month identifying Recipients who are eligible for the subsequent month. When such day is a holiday, then the parties agree to mutually agree upon a different day. The Contractor must reconcile Member and Capitation Payment information with the Department for Medicaid Services.		
		Specific data item requirements for the Contractor's recipient subsystem shall contain such items as maintenance of demographic data, matching Primary Care Providers with Members, maintenance information on Enrollments/Disenrollments, identification of TPL information, tracking EPSDT preventive services and referrals.		
4.1.2	34	**Third party Liability (TPL) Subsystem**		
		In order to ensure that federal third party liability requirements are met and to maximize savings from available Third Party Resources, identification and recovery of Third Party Resources must be a joint effort between the DMS and the Contractor. DMS will provide Contractor with the Medicare effective dates.		
		The Third Party Liability (TPL) processing function permits the Contractor to utilize the private health, Medicare, and other Third-Party Resources of its Members and ensures that the Contractor is the payer of last resort. This function works through a combination of cost avoidance (non-payment of billed amounts for which a third party may be liable) and post-payment recovery (post-payment collection of Contractor paid amounts for which a third party is liable).		
		Cost avoidance is the preferred method for processing claims with TPL. This method is implemented automatically by the MIS through application of edits and audits which check claim information against various data fields on recipient, TPL, reference, or other MIS files. Post-payment recovery is primarily a back-up process to cost avoidance, and is also used in certain situations where cost avoidance is impractical or unallowable.		
		42 CFR 433.138 requires that as a condition of Medicaid eligibility each Recipient will be required to:		
		(a) Assign, in writing, his/her rights to the Contractor for any medical support or other Third Party Payments for medical services provided by the Contractor; and		
		(b) Cooperate in identifying and providing information to assist the Contractor in pursuing third parties that may be liable to pay for care and services provided by the Contractor.		
		42 CFR 433.138 requires the Contractor be responsible for actively seeking and identifying third party resources, i.e. health or casualty insurance, liability insurance and attorneys retained for tort action, through contact with the Members, participating providers, and the Medicaid Agency.		
		42 CFR 433.139 requires the Contractor be responsible to assure that the Medicaid Program is the payer of last resort when other Third Party Resources are available to cover the costs of medical services provided to Medicaid Recipients. When the Contractor is aware of other Third Party Resources, the Contractor shall avoid payment by "cost avoiding" (denying) the claim and redirecting the provider to bill the other Third Party Resource as a primary payer. If the Contractor does not become aware of another Third Party Resource until after the payment for service, the Contractor is responsible to seek recovery from the Third Party Resource or the provider on a post-payment basis. See Attachment I .		
4.1.3	35	**Provider Subsystem**		
		The provider subsystem accepts and maintains comprehensive, current and historical information about Providers eligible to participate in the Contractor's Network. The maintenance of provider data is required to support claims and encounter processing, utilization/quality processing, financial processing and report functions. The Contractor will be required to electronically transmit provider enrollment information to DMS on a monthly basis, by the first Friday of the month following the month reported.		
		The Contractor's provider subsystem shall contain such items as demographic data, identification of provider type, specialty codes, maintenance of payment information, identification of licensing, credentialing/re-credentialing information and monitoring of Primary Care Provider capacity for enrollment purposes.		
		The Contractor shall demonstrate compliance with standards of provider network capacity and member access to services by producing reports illustrating that services, service locations, and service sites are available and accessible in terms of timeliness, amount, duration and personnel sufficient to provide all Covered Services on an emergency or urgent care basis, 24 hours a day, seven days a week.		
		DMS will monitor the Contractor's Network capacity and member access by use of a Decision Support System. The Encounter Record submitted will be used to display Primary Care Provider location, Service Location, Recipient distribution, patterns of referral, quality measures, and other analytical data.		
4.1.4	35	**Reference Subsystem**		

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		The reference subsystem maintains pricing files for procedures and drugs including Mental/Behavioral Health Drugs and maintains other general reference information such as diagnoses, edit/audit criteria, edit dispositions and reimbursement parameters/modifiers. The reference subsystem provides a consolidated source of reference information which is accessed by the MIS during the performance of other functions, including claims and encounter processing, TPL processing and utilization/quality reporting functions. DMS will provide advance notice to PHP regarding any changes in the fee schedule, expansion or reduction of covered services and benefit limitations.		
		The Contractor's reference subsystem shall contain such items as maintenance of procedure codes/NDC codes and diagnosis codes, identification of pricing files, maintenance of edit and audit criteria.		
4.1.5	35	**Claims Processing Subsystem**		
		The claims processing subsystem collects, processes, and stores data on all health services delivered. The functions of this subsystem are claims payment processing and capturing medical service utilization data. Claims are screened against the provider and recipient subsystems. The claims processing subsystem captures all medically related services, including medical supplies, using standard codes (e.g. HCPCS, ICD9-CM, UB92 Revenue Codes, ADA Dental Codes and NDCs) rendered by medical providers to a Member regardless of remuneration arrangement (e.g. capitation/fee-for-service). The Contractor shall be required to electronically transmit Encounter Record to DMS on a monthly basis.		
		The Contractor's claims processing subsystem shall contain such items as: apply edit and audit criteria to verify timely, accurate and complete Encounter Record; edit for prior-authorized Claims; identify error codes for claims.		
4.1.6	36	**Financial Subsystem**		
		The Financial subsystem function encompasses claim payment processing, adjustment processing, accounts receivable processing, and all other financial transaction processing. This subsystem ensures that all funds are appropriately disbursed for Claim payments and all post-payment transactions are applied accurately. The financial processing function is the last step in claims processing and produces remittance advice statements/explanation of benefits and financial reports.		
		The Contractor's financial subsystem shall contain such items as: update of provider payment data, tracking of financial transactions, including TPL recoveries and maintenance of adjustment and recoupment processes.		
4.1.7	36	**Utilization / Quality Improvement Subsystem**		
		The Contractor shall capture and maintain a patient-level record of each service provided to Members using CMS 1500, UB92, UBO4, NCPDP, HIPAA code sets or other claim or claim formats that shall meet the reporting requirements in this Contract. The computerized database must contain and hold a complete and accurate representation of all services covered by the Contractor, and by all providers and Subcontractors rendering services for the contract period. The Contractor shall be responsible for monitoring the integrity of the database and facilitating its appropriate use for such required reports as encounter data, and targeted performance improvement studies.		
		Contractor shall comply with the expectations of 42 CFR 455.20 (a) by employing a method of verifying with recipients whether the services billed by provider were received.	Not included	Not included
		The utilization/quality improvement subsystem combines data from other subsystems, and/or external systems, to produce reports for analysis which focus on the review and assessment of access, availability and continuity of services, quality of care given, detection of over and under utilization of services, and the development of use-defined reporting criteria and standards. This system profiles utilization of Providers and Members and compares them against experience and norms for comparable individuals.		
		The subsystem supports tracking utilization control function(s) and monitoring activities, including Geo Network for all Encounters in all settings particularly in-patient and outpatient care, emergency room use, outpatient drug therapy, EPSDT and out-of-area services. It completes provider profiles; occurrence reporting, including adverse incidents and complications, monitoring and evaluation studies; Members and Providers aggregate Grievances and Appeals; effects of educational programs; and Member/Provider satisfaction survey compilations. The subsystem may integrate the Contractor's manual and automated processes or incorporate other software reporting and/or analysis programs.		
		The Contractor's utilization/quality improvement subsystem shall contain such items as: monitoring of primary care and specialty provider referral patterns, processes to monitor and identify deviations in patterns of treatment from established standards or norms, performance and health outcome measures using standardized indicators. The quality improvement subsystem will be based upon nationally recognized standards and guidelines, including but not limited to, a measurement system based upon the most current version of HEDIS published by the national Committee for Quality Assurance.		
4.1.8	37	**Analysis and Reporting Capacity**		
		The analysis capacity function supports reporting requirements for the Contractor and DMS with regard to the QAPI program and managed care operations. The Contractor shall show sufficient capacity to support special requests and studies that may be part of the financial and quality systems. The reporting subsystem allows the Contractor to develop various reports to enable Contractor management and the DMS to make informed decisions regarding managed care activity, costs and quality.		
		The Contractor's reporting subsystem shall contain such items as: specifications for a decision support system; capacity to collect, analyze and report performance data sets such as may be required under this Contract; HEDIS performance measures; report on Provider rates, federally required services, reports such as family planning services, abortions, sterilizations and EPSDT services.		
4.2	37	**Encounter Data System**		
		The Contractor shall ensure that Encounter Records are consistent with the terms of this Contract and all applicable state and federal laws. The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports, and Encounter Record set in formats and timelines prescribed by the Department as defined in the Contract. The system shall be capable of following or tracing an Encounter within its system using a unique Encounter Record identification number for each Encounter. At a minimum, the Contractor shall be required to electronically provide Encounter Record to DMS on a monthly basis. Encounter Record must follow the format, data elements and method of transmission specified by the DMS. All changes to edits and processing requirements due to Federal or Statutory changes shall be provided to the Contractor in writing no less than sixty (60) working days prior to implementation.		
		The Contractor shall submit electronic test data files as required by the Department in the format referenced in this Contract and as specified by the Department. The electronic test files are subject to Department review and approval before production of data. DMS will process the Encounter Record through defined edit and audit requirements and reject Encounter Record that does not meet its requirements. Threshold and informational editing shall apply. The Department reserves the right to change the number of, and the types of edits used for threshold processing based on its review of the Contractor's monthly transmissions. The Contractor shall be given sixty (60) working days prior notice of the addition/deletion of any of the edits used for threshold editing. The Encounter Record will be utilized by DMS for the following:		
		(a) To evaluate access to health care, availability of services, quality of care and cost effectiveness of services,		
		(b) To evaluate contractual performance,		
		(c) To validate required reporting of utilization of services,		
		(d) To develop and evaluate proposed or existing Capitation Rates, and		
		(e) To meet CMS Medicaid reporting requirements.		

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		(f) For any purpose the Department deems necessary.		
		Data quality efforts of the Department shall incorporate the following standards for monitoring and validation:		
		(a) Edit each data element on the Encounter Record for required presence, format, consistency, reasonableness and/or allowable values.		
		(b) Edit for Member eligibility.		
		(c) Perform automated audit processing (e.g. duplicate, conflict, etc.) using history Encounter Record and same-cycle Encounter Record.		
		(d) Identify exact duplicate Encounter Record.		
		(e) Maintain an audit trail of all error code occurrences linked to a specific Encounter.		
		(f) Update Encounter history files with both processed and incomplete Encounter Record.		
		The Contractor shall have the capacity to track and report on all Erred Encounter Records.		
		The Contractor shall be required to use procedure codes, diagnosis codes and other codes used for reporting Encounter Record in accordance with guidelines defined by DMS in writing. The Contractor must also use appropriate Provider numbers for Encounter Records as directed by DMS. The Encounter Record shall be received and processed by DMS' Fiscal Agent and shall be stored in the existing MMIS.		
		All Subcontracts with Providers or other vendors of service must have provisions requiring that Encounter Record is reported/submitted in an accurate and timely fashion.		
		The Contractor shall specify to the Department the name of the primary contact person assigned responsibility for submitting and correcting Encounter Record, and a secondary contact person in the event the primary contact person is not available.		
4.4	39	**Penalties**		
		If the Contractor fails to submit health care data derived from processed Claims or Encounter Record as required by the terms of this Contract or data from processed Claims otherwise specified by the Department pursuant to this Contract, and after the Department has provided Contractor at least sixty (60) working days prior written notice of the specific requirements for submitting the Encounter Record, the Department may withhold an amount commensurate with harm but not to exceed ten percent (10%) of the Contractor's Capitation Payment for the month following non-submission of data. The Department shall retain the amount withheld until the data is received and accepted by the Department. Any other health care data requested by the Department or required pursuant to this Contract, including social and demographic data, shall be submitted to the Department in accordance with the time frames developed by the Department which shall take into consideration the purpose for the data requested, the availability ofovision (907 KAR Chapter 1 and 907 KAR 3:005) and individual Medicaid program services manuals incorporated by r		
		The Department will work with the Contractor to resolve problems in obtaining data at all times. The Contractor acknowledges its responsibility to provide data on Members upon request. It is further understood that no withhold will be applied if the reason for delay is beyond control of the Contractor as reasonably determined by the Department.		
		Erred Encounter Records shall be transmitted to the Contractor electronically for correction and resubmission. EPSDT Encounter Record shall be completed in accordance with Section 10.4 and these penalties may apply.		
		Quality Assessment / Performance Improvement (QAPI)		
5.8	51	**Utilization Management**		
		The Contractor shall have a comprehensive utilization management (UM) program that reviews services for Medical Necessity and that monitors and evaluates on an ongoing basis the appropriateness of care and services. A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities. The description shall include the scope of the program; the processes and information sources used to determine service coverage; clinical necessity, appropriateness and effectiveness; policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery; processes to review, approve and deny services, as needed. The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes. The UM program evaluation along with any changes ovision (907 KAR Chapter 1 and 907 KAR 3:005) and individual Medicaid program services manuals incorporated by reference in the administrativ		
		The Contractor shall develop or adopt written Medical Necessity review criteria that are based on sound medical evidence or judgment and shall review such criteria periodically and update as needed. The Contractor shall include appropriate physicians and other providers in Contractor's Network in the review and adoption of Medical Necessity criteria. The Contractor shall have in place mechanisms to check the consistency of application of review criteria. The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate. The Medical Director shall supervise the UM program and shall be accessible and available for consultation as needed.		
		Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease. The reason for the denial shall be cited. Qualified professionals shall make decisions requiring clinical judgment and denials based on lack of Medical Necessity. A physician licensed by a Medical Board of Licensure shall make denials for preauthorization or continued stay in a hospital based on Medical Necessity. Physician consultants from appropriate medical and surgical specialties shall be accessible and available for consultation as needed. The Medical Necessity review process shall be timely and shall include a provision for expedited reviews in urgent decisions. If a Member has no financial liability, notification of an adverse decision is not required. The UM program, processes, and timeframes shall be in accordance with 42 CFR 456, 42 ovision (907 KAR Chapter 1 and 907 KAR 3:005) and individual M		
		The Contractor will submit its request to change any prior authorization requirement to the Partnership Council, and the Contractor shall also submit the change to the Department for the Department to assure that the benefits offered by Contractor are at least the same offered to members not enrolled in Passport.		
		For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.		
		The Contractors written policies and procedures shall identify the timeframes for review and decisions, and the Contractor shall demonstrate that the timeframes are consistent with the following required maximum timeframes:		
		1. Within one (1) business day of receipt of request for urgent or emergent inpatient admissions and concurrent review.		
		2. Within two (2) business days from receipt of request for non-urgent.		
		3. Within ten (10) business days of receipt of request for retrospective reviews.		

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		In the event that a Member or Provider requests written confirmation of an approval, the Contractor shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial decision was not in writing. The written confirmation shall be written in accordance with Section 7.1.4.		
		The Contractors written policies and procedures shall show how the Contractor will monitor to ensure adequate care management and overall continuity of care.		
		The Contractor's written policies and procedures shall explain how prior authorization data will be incorporated into the Contractor's overall Quality Improvement Plan.		
		Each subcontract must provide that consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member.		
		The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services. The written program description shall address the procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes and the process used to review and approve the provision of medical services. The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys. The UM program will be evaluated by DMS on an annual basis.		
		Provider Services		
6.1	55	**Required Services**		
		The Contractor shall maintain a Provider Services function that is responsible for the following services and tasks:		
		(a) Assisting Providers with Member Enrollment status questions;		
		(b) Assisting Providers with Prior Authorization and referral procedures;		
		(c) Assisting Providers with Claims submissions and payments;		
		(d) Explaining to Providers their rights and responsibilities as a member of Contractor's Network;		
		(e) Handling, recording and tracking Provider Grievances and Appeals properly and timely;		
		(f) Developing, distributing and maintaining a Provider manual;		
		(g) Developing, conducting, and assuring Provider orientation/training;		
		(h) Explaining the extent of Medicaid benefit coverage to Providers including EPSDT preventive health screening services and EPSDT Special Services;		
		(i) Communicating Medicaid policies and procedures, including state and federal mandates and any new policies and procedures;		
		(j) Assisting Providers in coordination of care for child and adult members with complex and/or chronic conditions;		
		(k) Encouraging and coordinating the enrollment of Primary Care Providers in the Department for Public Health and the Department for Medicaid Services Vaccines for Children Program. This program offers certain vaccines free of charge to Medicaid members under the age of 21 years;		
		(l) Coordinating workshops relating to the Contractor's policies and procedures; and		
		(m) Providing necessary technical support to Providers who experience unique problems with certain Members in their provision of services.		
	56	Provider Services shall be staffed, at a minimum, Monday through Friday during regular business hours. Staff members shall be available to speak with Providers any time during business hours. **Provide a back-up telephone system that will operate, in the event of line trouble or other problems, so that access to the call center by telephone is not disrupted.** The Contractor's provider services function shall develop and maintain a staff ratio in proportion to the Contractor's enrollment or projected enrollment. Provider Services staff shall be instructed to follow contractually required provider relation functions including, policies, procedures and scope of services.	Bold not included	Bold not included
6.3	62	**Primary Care Provider Responsibilities**		
		Unless otherwise required hereunder, the PCP shall serve as the Member's initial and most important point of contact with the Contractor.		
		Specialty providers may serve as PCPs under certain circumstances, depending on the Member's needs. The decision to utilize a specialist as the PCP shall be based on agreement among the Member or family, the specialist, and the Contractor's medical director. The Member has the right to Appeal such a decision in the formal Appeals process.		
		The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's policies including but not limited to the following:		
		(a) Maintaining continuity of the Member's health care;		
		(b) Making referrals for specialty care and other Medically Necessary services, both in and out of plan, if such services are not available within the Contractor's Network;		
		(c) Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;		
		(d) Discussing Advance Medical Directives with all Members as appropriate;		
		(e) Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years; and		
		(f) Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications.		
		(g) Arranging and referring members when clinically appropriate, to behavioral health providers.		
		Maintaining formalized relationships with other PCPs to refer their Members for after hours care, during certain days, for certain services, or other reasons to extend their practice. The PCP remains solely responsible for the PCP functions (a) through (g) above.		
		The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by PCPs in Contractor's Network and that the unacceptable arrangements are not implemented:		
		(h) Acceptable		
		1. Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes.		
		2. Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes.		
		3. Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.		
		(i) Unacceptable		
		1. Office phone is only answered during office hours.		
		2. Office phone is answered after hours by a recording that tells Members to leave a message.		
		3. Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed.		

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6.8.1	64	**Network Providers to Be Enrolled**		
		The Contractor's Network shall include Providers from throughout the provider community. The Contractor shall comply with the any willing provider rule as described in 907 KAR 1:672 and KRS 304.17A-270. The Contractor shall enroll into its network, physicians, certified registered nurse practitioners, physician assistants, birthing centers, dentists, primary care centers including Federally Qualified Health Centers (FQHCs), rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, pharmacies, durable medical equipment suppliers, podiatrists, renal dialysis clinics, ambulatory surgical centers, family planning providers, emergency medical transportation services, certified registered nurse anesthetists, other laboratory and x-ray services, individuals and clinics providing Early and Periodic Screening, Diagnosis, and Treatment services, and providers of EPSDT Special Services. Enrollment forms shall include those used by the Kentucky Medicaid Program as pertains to the provider type. ovision (907 KAR Chapter 1 and 907 KAR 3:005) and individual Medicaid program services manuals incorporated by ref		
		In order to prevent duplication of effort by the Contractor, the Department will continue to enroll and certify hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, and hospices. The Medicaid provider file will be available for review by the Contractor so that they can ascertain the status of a Provider with the Medicaid Program and the provider number assigned by the Kentucky Medicaid Program. The Department shall continue to enroll Providers whose services are not included in the managed care plan.		
		Providers performing laboratory tests are required to be certified under the CLIA. The DMS will continue to update the provider file with CLIA information from the OSCAR file provided by the Centers for Medicare & Medicaid Services for all appropriate providers. This will make laboratory certification information available to the Contractor on the Medicaid provider file.		
		The Contractor shall have written policies and procedures regarding the selection and retention of Contractor's Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.		
6.8.2.1	65	**Providers Eligible and Ineligible for Enrollment**		
		Providers contracting with the Contractor to perform medical services shall enroll with the Partnership Program regardless of their participation in the Kentucky Medicaid Program. Providers shall meet the credentialing standards described in Section 6.2 of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. The Contractor shall provide written notice to Providers not accepted into the network along with the reasons for the nonacceptance.		
		A prospective provider cannot enroll in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider's eligibility for Contractor participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.		
6.8.2.3	66	**Enrolling New Providers and Providers not Participating in Medicaid**		
		A medical provider is not required to participate in the Kentucky Medicaid Program as a condition of participation with the Contractor's Network. If a potential Provider has not had a Medicaid number assigned, the Contractor will obtain all data and forms necessary to enroll within the Contractor's Network, and include the required data in any transmission of the provider file information with the exception of the Medicaid provider number. Provider file records transmitted without a provider number will be suspended until verification of the provider's Medicaid enrollment status and for the assignment of the provider number. When eligibility is confirmed, the Department will enter the provider number on the master provider file and the transmitted data will be loaded to the provider file. The Contractor will receive a report within two weeks of the transmission of transactions accepted, suspended, and denied.		
		All documentation regarding a provider's qualifications and services provided shall be available for review by the Department or its agents at the Contractor's offices at any time without interference.		
6.8.2.8	67	**Out of network Providers**		
		Out of Network Providers seen by foster care Members or by Members for Emergency Care will not have to be made a part of the Contractor's Network. The Department will provide the Contractor with a streamlined enrollment process to assign provider numbers to use when reporting Encounter data by Out of Network Providers. **Only out of network hospitals, physicians, and pharmacies are allowed to complete the Registration short form in emergency situations.** The streamlined enrollment process will enable the Encounter Record to be accepted for processing. The Contractor shall, in a format specified by the Department report all out of network utilization by Members	Same	Bold not included
6.8.2.11	71	**Expansion and/or Changes in the Network**		
		If at any time, the Contractor determines that its Contractor Network is not adequate to comply with the access standards specified above, the Contractor shall notify DMS of this situation and submit a corrective action plan to remedy the deficiency. The corrective action plan shall describe the deficiency in detail, including the geographic location and specific regions where the problem exists, and identify specific action steps to be taken by the Contractor and time- frames to correct the deficiency.		
		In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make every effort to recruit additional providers based on Member requests. When Members ask to receive services from a provider not currently enrolled in the Partnership Program, the Contractor shall contact that provider to determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.		
		In the event a PCP ceases participation voluntarily in the Partnership Program, the Contractor shall notify DMS, in writing, at least 30 calendar days prior to the PCP termination date, or of the Partnership Program's notification to the PCP to terminate the Provider's participation. In the event a PCP ceases participation involuntarily in the Partnership Program, the Contractor shall notify DMS, in writing, at least 15 days after the PCP termination date. The Contractor shall indicate in its notice to DMS the reason or reasons for which the PCP ceases participation.		

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		The Contractor shall submit to DMS on a quarterly basis, in a format specified by the DMS, a report summarizing changes in the Contractor's Network. The Contractor shall report to the Department all provider groups, clinics, facilities and individual physician practices and sites in its network that are not accepting new Medicaid Members. This report will include the number of Providers who are not accepting new Members. The Contractor shall have procedures to address changes in its Partnership Program that reduce Member access to services. Significant changes in Partnership Program composition that reduce Member access to services may be grounds for contract termination.		
		Member Services		
7.1	72	**Member Services Functions**		
		The Contractor shall have a Member Services function which is staffed Monday through Friday during regular business hours. Staff shall be available to speak face-to-face or by telephone with Members at any time during business hours. The Contractor shall have a toll-free 24-hour, seven-days-per-week Member Services telephone number and a telecommunication device for the deaf to assist members in obtaining and appropriately using Emergency Care or Urgent Care. **Provide a back-up telephone system that will operate, in the event of line trouble or other problems, so that access to the call center by telephone is not disrupted.**		
		The Contractor shall maintain a Member Services staff ratio in proportion to the Contractor's enrollment or projected enrollment. Appropriate foreign language interpreters shall be available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education. Member materials shall be provided and printed in each language spoken by ten percent (10%) or more of the Members in each county. The Contractor staff shall be able to respond to the special communication need of the disabled, blind, deaf and aged and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.	Bold not included	Bold not included
		The Contractor shall require by contract with its Subcontractors that all Service Locations meet the requirements of the Americans with Disabilities Act, and all Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures, which are applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to a Member's records when written Member consent is provided.		
		The Contractor's Member Services function shall also be responsible for:		
		(a) Representing the interests of Members before the boards of the Contractor and the Department;		
		(b) Reviewing and commenting on policies of the Contractor and the Department;		
		(c) Ensuring that Members are informed of their rights and responsibilities;		
		(d) Monitoring the selection and assignment process of PCPs;		
		(e) Identifying, investigating, and resolving Member Grievances about health care services;		
		(f) Assisting Members with filing formal Appeals regarding plan determinations.		
		(g) Providing each Member with an identification card that identifies the Member as a participant in the Partnership Program, unless otherwise approved by the Department;		
		(h) Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;		
		(i) Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;		
		(j) Within two weeks of enrollment notification, and whenever requested by member, guardian or authorized representative, provide a member Handbook and information on how to access services; (alternate notification methods must be available for persons who have reading difficulties or visual impairments);		
		(k) Explaining or answering any questions regarding the Member Handbook;		
		(l) Facilitating the selection of or explaining the process to select or change Primary care providers through telephone or face-to-face contact where appropriate. The Contractor shall assist members to make the more appropriate Primary care Provider selection based on previous or current Primary Care Provider relationship, providers of other family members, medical history, language needs, provider location and other factors that are important to the member. The Contractor shall notify members within thirty (30) days prior to the effective date of voluntary termination (or if Provider notifies Contractor less than thirty (30) days prior to the effective date, as soon as Contractor receives notice), and within fifteen (15) days prior to the effective date of involuntary termination if their Primary Care Provider leaves the Program and assist Members in selecting a new Primary Care Provider;		
		(m) Facilitating direct access to specialty physicians in the circumstances of:		
		1. members with long-term, complex conditions;		
		2. Aged, blind, deaf, or disabled persons, and		
		3. Individuals who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through standing referrals from the Primary Care Provider or by the specialty physician being permitted to serve as the Primary Care Provider.		
		(n) Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing Early and Periodic Screening, Diagnosis and Treatment for persons under the age of twenty-one (21) years;		
		(o) Making referrals for relevant non-Program provider services such as the Women, Infants and Children (WIC) supplemental nutrition program and Protection and Permanency;		
		(p) Facilitating direct access to primary care vision services; primary dental and oral surgery services and evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases; all as further described in Attachment V of this Contract;		
		(q) Facilitating access to pharmaceutical services;		
		(r) Facilitating access to the services of public health departments, rural health clinics, Federally Qualified Health Centers, the Commission for Children with Special Health Care Needs and charitable care providers, such as Shriners Hospital for Children;		
		(s) Assisting members in making appointments with Providers and obtaining services. When the Contractor is unable to meet the accessibility standards for access to Primary Care Providers or referrals to specialty providers, the Member Services staff function must document and refer such problems to the designated Contractor liaison and Quality and Member Access Advisory Committee for resolution;		
		(t) Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;		
		(u) Assisting Dual Eligible Members to access necessary services;		
		(v) Handling, recording and tracking Member Grievances properly and timely and acting as an advocate to assure Members receive adequate representation when seeking an expedited Appeal;		

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		(w) Facilitating access to Member Health Education Programs;		
		(x) Assisting members in completing the Health Risk Assessment (HRA) form upon any telephone contact; and referring Members to the appropriate areas to learn how to access the health education and prevention opportunities available to them including referral to case management or disease management.		
		(y) Providing Members with information related to support services offered outside the Partnership Program such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse.		
		The Member Services staff shall be responsible for making an annual report to management about any changes needed in Member Services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department and the Quality and Member Access Advisory Committee.		
7.1.5	79	**Choice of Providers**		
		Dual Eligible Members, where Medicare is the primary insurer, and Members who are presumptively eligible or foster children, are not required to have a PCP. All other Members in the Partnership must choose or have the Plan select a PCP for their medical home.		
		The Contractor shall determine a method for assignment of Primary Care Providers which is consistent with the any willing provider statute, KRS 304.17A-270.		
		There are two different processes for choosing a PCP for those Members who are eligible for a PCP relationship: (a) one process for Members who have SSI coverage but are not Dual Eligible Members, and (b) one process for all other Members.		
		Selection of PCP for Members Who Do Not Have SSI. Except as specified below regarding Members who have SSI coverage but are not Dual Eligible Members, all Members shall be offered the opportunity to: (1) choose a new PCP who is affiliated with the Partnership Program or (2) stay with their current PCP as long as such PCP is affiliated with the Partnership Program. Each Member shall be allowed to choose his or her Primary Care Provider from among all available Contractor Network Primary Care Providers and specialists as is reasonable and appropriate for Member. A Member who has received Prior Authorization from the Contractor for referral to a specialist physician or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's Network, to the extent reasonable and appropriate.		
		The Contractor shall have procedures for serving Members from the date of notification of eligibility, whether or not the Member has selected a Primary Care Provider. The Contractor shall send Members a written explanation of the Primary Care Provider selection process within ten (10) business days of receiving enrollment notification from DMS. Members will be asked to select a Primary Care Provider and contact the Contractor's Member Services department with their selection. The written communication shall include the timeframe for selection of a Primary Care Provider, an explanation of the process for assignment of a Primary Care provider if the Member does not select a Primary Care Provider and information on where to call for assistance with the selection process.		
		A Member shall be allowed to select, from all available, but not less than two (2) Primary Care Providers in the Contractor's Network at least one (1) of which shall be a Primary Care Provider.		
		If the Member does not make voluntary selection of a Primary Care Provider, the Contractor shall assign the Member to a Primary Care Provider:		
		(a) Who has historically provided services to the Member and meets the Primary Care Provider criteria and participates in the Contractor's Network;		
		(b) If there is no such Primary Care Provider who has historically provided services, the Contractor shall assign the Member to a Primary Care Provider, who participates in the Contractor's Network and is within thirty (30) miles or thirty (30) minutes from the Member's residence or place of employment in an urban area or within forty-five (45) miles or forty-five (45) minutes from the Member's residence or place of employment in a rural area.		
		The assignment shall be based on the following:		
		(1) The need of children and adolescents to be followed by pediatric or adolescent specialists;		
		(2) Any special medical needs, including pregnancy;		
		(3) Any language needs **made known to the Plan**; and	Bold not included	Bold not included
		(4) Area of residence and access to transportation.		
		(c) If there is no Primary Care Provider in the Contractor's Network that meets the criteria listed in paragraphs (a) and (b) directly above, the Contractor shall assign the Member to any Network Primary Care Provider in an adjoining county to the Member's county of residence or within the Partnership Region.		
		The Contractor shall monitor and document in a quarterly report to the Department the number of eligible individuals that are assigned a PCP. The Contractor shall notify the Member, in writing, of the PCP assignment, including the Provider's name, and office telephone number. The Contractor shall make available to the PCP a capitation roster on the first day of each month a listing of Members who have selected or been assigned to his/her care		
		Selection of PCP for Members who have SSI but are not Dual Eligible Members. The Contractor will send such Members information regarding the requirement to select a PCP, or one will be assigned to them in the following format:		
		(a) Upon Enrollment, such Member will receive a letter requesting them to select a PCP. After one month, if the Member has not selected a PCP, the Partnership Program must send a second letter requesting the Member to select a PCP within thirty (30) days or one will be chosen for the Member.		
		(b) At the end of the third thirty (30) day period, if the Member has not selected a PCP, the Partnership Program may select a PCP for the Member and send a card identifying the PCP selected for the Member and informing the Member specifically that the Member can contact the Partnership Program and make a PCP change.		
		(c) Except for Members who were previously enrolled, the Contractor cannot auto-assign a PCP to an SSI member within the first ninety (90) days from the date of the Member's initial enrollment.		
7.1.6	81	**PCP Changes**		
		The Contractor shall have written policies and procedures for allowing Members to select or be assigned to a new PCP when such a change is mutually agreed to by the Contractor and Member, when a pcp is terminated from coverage, or when a pcp change is ordered as part of the resolution to an Appeal. The Contractor shall allow Members to select another pcp within ten (10) days of the approved change or the Contractor shall assign a pcp to the Member if a selection is not made within the time frame.		
		A Member shall have the right to change the PCP 90 days after the initial assignment and once a year regardless of reason, and at any time for any reason as approved by the Member's Contractor. The Member may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Member to miss the annual opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Member and/or the PCP are no longer located in the Partnership Region.		

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		The Member shall also have the right to terminate the PCP at any time for cause. Good cause includes the Member was denied access to needed medical services; the Member received poor quality of care; and the Member does not have access to providers qualified to treat his or her health care needs. If the Contractor approves the Member's request, the assignment will occur no later than the first day of the second month following the month of the request.		
		PCPs shall have the right to request a Member's Disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship; inability to meet the medical needs of the Member; or upon determination by the Contractor. PCPs shall not have the right to request a Member's Disenrollment from their practice in the following situations: a change in the Member's health status or need for treatment; a Member's utilization of medical services; a Member's diminished mental capacity; or, disruptive behavior that results from the Member's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Member or others. Transfer requests shall not be based on the grounds of race, color, national origin, handicap, age or gender. The Contractor shall approve all transfers.		
		The initial Provider must serve until the new Provider begins serving the Member, barring ethical or legal issues. The Member has the right to Appeal such a transfer in the formal Appeals process.		
		The provider shall make the change request in writing. **Member may request PCP change in writing, face to face or via telephone.**	Bold not included	Bold not included
7.2	82	**Grievance System**		
		The Contractor shall have an organized Grievance system that shall include a Grievance process, an Appeal process, and access for Members to the State's hearing system. Any Member has a right to file a Grievance with the Contractor or the Department if they are dissatisfied with anything related to the Partnership Program. Any Member may file an Appeal related to Actions, or a decision by the Contractor related to Covered Services or services provided.		
		The Contractor shall acknowledge receipt of each Grievance and Appeal. The Contractor shall provide notice to the Member and must ensure that decision-makers on Grievances and Appeals were not involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the Member's condition if:		
		(a) A Denial based on lack of Medical Necessity;		
		(b) A Grievance regarding denial of expedited resolutions of an Appeal; and		
		(c) Any Grievance or Appeal involving clinical issues.		
7.2.1	83	**Grievances**		
		Any Member shall have the right to file a Grievance with the Contractor if they are dissatisfied with a matter regarding the management of their care. Any dissatisfaction concerning eligibility matters shall be filed with the Department for Community Based Services.		
7.3	88	**Eligibility**		
7.3.1		**Persons Eligible for Enrollment**		
		Recipients eligible to enroll in the Partnership Program may be eligible beginning with the first day of the application month with the exception of (1) newborns who are eligible beginning with their date of birth and (2) unemployed parent program Recipients who are eligible beginning with the date the definition of "unemployment" or "underemployment" is met.		
		To be eligible to be a Member, a person must be a Recipient, in addition, a Recipient shall be a resident of the Partnership Region, shall not reside in a Service Location and must have qualified to receive medical assistance under one of the aid categories defined below:		
		ELIGIBLE RECIPIENT CATEGORIES		
		Aid to Families with Dependent Children (AFDC) / Temporary Assistance to Needy Families (TANF)*		
		Children and family related		
		Aged, blind, and disabled Medicaid only		
		Pass through		
		Poverty level pregnant women and children, including presumptive eligibility		
		State supplementation for aged, blind, and disabled		
		Supplemental Security Income (SSI)		
		Under the age of twenty-one (21) years and in a psychiatric residential treatment facility (PRTF)		
		Under the age of eighteen (18) years, placed in foster care and under supervision of a Kentucky public or private child welfare agency and Adult Guardianship clients		
		Children under the age of eighteen (18) who are adopted and have special needs		
		A SSI recipient may reside in a service location.		
		The Contractor shall provide services to individuals who would have been eligible to receive Aid to Families with Dependent Children (AFDC) and Medicaid in accordance with AFDC requirements as in effect as of July 16, 1996, as subsequently amended in accordance with 42 USC 1396u-1, and as required by federal and state laws or by administrative regulation.		
7.3.2.2	91	**Eligibility Determination**		
		The Department through its agent shall be solely responsible for determining the eligibility of Members for enrollment in the Partnership Program. Member's eligibility for Medicaid is re-evaluated periodically by the agent. The Department shall provide the Contractor with information relative to each Member's continued eligibility for enrollment.		
7.3.3	91	**Moving Out of the Partnership Region**		
		The Contractor shall continue to be responsible for the provision and cost of medical care of any Member moving out of the Partnership's Region until such time as the Member is removed from the Member Listing Report. The Department shall continue Capitation Payments to the Contractor on behalf of the Member until such time as the Member's change of residence is updated in the eligibility system and the Member's name is removed from the Member Listing Report. The Department shall notify the Contractor promptly upon the removal of the Member from the Partnership Program.		
7.4.5	92	**Member Listing Report**		
		The Department will electronically transmit to the Contractor a Member Listing Report on or before the Thursday before the last Friday on each month listing all Members in the Partnership Program as of the 25th day of the month who are eligible for the subsequent month. The Department will electronically transmit an adjusted monthly Member Listing Report reconciling enrollment information four (4) months prior to the processing month in order to identify all Recipients who were newly added retroactively or who were incorrectly omitted or any other changes or corrections to the Member Listing Report.		

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		All Enrollments and Disenrollments shall become effective on the first day of the calendar month for which the Enrollment or Disenrollment is listed on the Member Listing Report. The Member Listing Report and adjusted Member Listing Report shall serve as the basis for Capitated Payments to the Contractor for the ensuing month.		
		The Contractor will be responsible for promptly notifying the Department of Recipients of whom it has knowledge were not included on the Member Listing Report and should have been enrolled in the Partnership Program.		
7.5	93	**Disenrollment**		
7.5.1		**Member Request for Disenrollment**		
		A Member may request Disenrollment from the Partnership Program only with cause and only if the Department grants the Member's request. The Member shall submit a written request for a hearing to request Disenrollment from the Partnership Program to either the Contractor or the Department. If submitted to the Contractor, the Contractor shall transmit the Member's request to the Contract Compliance Officer of the Department.		
7.5.2	93	**Disenrollment**		
		The Contractor shall recommend to the department Disenrollment of a Member when the Member:		
		(a) Is found guilty of Fraud in a court of law or administratively determined to have committed Fraud related to the Medicaid Program;		
		(b) Is abusive or threatening as defined by and reported in Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers to either Contractor, Contractor's agents, or providers;		
		(c) Becomes deceased;		
		(d) No longer resides in the Partnership Region;		
		(e) Is admitted to a nursing facility for more than 31 days;		
		(f) Is incarcerated in a correctional facility, or		
		(g) No longer qualifies for Medical Assistance under one of the aid categories listed in Section 7.3 of this Contract.		
		All requests by the Contractor for the Department to disenroll a Member shall be in writing and shall specify the basis for the request. If applicable, the Contractor's request must document that reasonable steps were taken to educate the Member regarding proper behavior, and that the Member refused to comply. The Contractor may not request Disenrollment of a Member based on an adverse change in the Member's health.		
7.5.3	93	**Effective Date**		
		Disenrollment shall be effective on the first day of the calendar month for which the Disenrollment appears on the Member Listing Report. Requested Disenrollment shall be effective no later than the first day of the second month following the month the Member or the Contractor files the request. If the Department fails to make a determination within the timeframes the Disenrollment shall be considered approved.		
7.6	94	**Marketing**		
		The Contractor may conduct Member Marketing and Enrollment activities only with Recipients residing in the Partnership's Region. The Contractor is prohibited from point-of-sale marketing to Recipients. The Contractor shall establish and at all times maintain a system of control over the content, form, and method of dissemination of its Marketing and information materials. The Contractor shall submit any marketing plans and all marketing materials to the Department and shall obtain the written approval of the Department prior to implementing any marketing plan or arranging for the distribution of any marketing materials to Recipients. The Contractor shall include in the plan the methods and procedures to log and resolve marketing Grievances. The Contractor may conduct mass media advertising directed to Recipients in the Partnership Region pursuant to a marketing plan and using marketing material(s) that have been first submitted to and approved, in writing, by the Department.		
		Any marketing materials referring to the Partnership Program must be approved in writing by the Department prior to dissemination, including mailings sent only to Members. The Contractor agrees to engage only in marketing activities that are pre-approved in writing by the Department. The Contractor must correct problems and errors subsequently identified by the Department after notification by the Department.		
7.6.1	94	**Marketing Rules**		
		In developing marketing materials such as written brochures, fact sheets, and posters, the Contractor shall abide by the following rules:		
		(a) No fraudulent, misleading, or misrepresentative information shall be used in the marketing materials;		
		(b) No offers of material or financial gain shall be made to Recipients as an inducement to select a particular provider or use a product;		
		(c) No offers of material or financial gain shall be made to any person for the purpose of soliciting, referring or otherwise facilitating the enrollment of any Recipient;		
		(d) No direct telephone marketing or direct mail advertising to Recipients who are not enrolled in a Partnership;		
		(e) All marketing materials shall provide a reasonable explanation of the Partnership Program and the Contractor's Network; and		
		(f) All materials cannot contain any assertion or statement (whether written or oral) that CMS, the federal government, the Commonwealth, or any other similar entity endorses the Partnership Program.		
7.6.2	95	**Marketing and Enrollment Agent**		
		The Department reserves the right to delegate to an independent agent or agents, the responsibility for determining the eligibility of Recipients for enrollment in the Partnership Program pursuant to Section 7.3 of this Contract; and disenrolling Members from the Partnership Program in accordance with Section 7.5 of this Contract.		
		In the event an agent is designated according to the terms of this Contract, the Department shall have the right to prescribe the application and Disenrollment forms to be used by the Contractor and the agent. The Department shall provide written notice to the Contractor identifying the agent or agents, if any, selected by the Department pursuant to this subsection, and setting forth the functions of the agent or agents, and procedures to be followed by the Contractor and its agents.		
		Covered Services		
8.1	95	**Medicaid Covered Services**		

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		The Contractor shall provide, or arrange for the provision of, the Covered Services listed in Attachment V to all Members in accordance with the standards set forth in this Contract, and according to the Department's policies and procedures applicable to each category of Covered Services. The Contractor shall be required to provide Covered Services to the extent services are covered for Recipients at the time of Enrollment. The Contractor shall ensure that the care of new enrollees is not disrupted or interrupted. The Contractor must ensure continuity of care for new Members receiving health care under fee for service prior to enrollment in the Plan. Attachment V shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Members. However, it is not meant, nor shall it serve as a substitute for the more detailed information relating to Covered Services which is contained in applicable administrative regulations governing Kentucky Medicaid services provision (907 KAR Chapter 1 and 907 KAR 3:005) and individual Medicaid program services manuals incorporated by reference in the administrative regulations.		
		If the Contractor questions whether a service is covered or not covered, the Department shall reserve the right to make the final determination based on Kentucky administrative regulations in effect at the time the Contract is negotiated in accordance with KRS Chapter 45A.		
		The Contractor may provide, or arrange to provide, services in addition to the services described in Attachment V, provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective, and the added services do not affect the Capitation Rate. The Contractor shall notify and obtain approval from DMS for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.		
		If coverage of any Medicaid service provided by the Contractor requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate Kentucky Administrative Regulation (KAR). The Contractor shall require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request. Failure to follow applicable regulations and properly complete and maintain specific forms as required shall result in the application of sanctions as provided in this Contract. The preceding clause is not to be construed as requiring the Contractor to provide coverage for counseling or referral service if it objects to the service on moral or religious grounds and makes available information on its policies and to Members within ninety (90) Days after the date the organization adopts a change in policy regarding such a counseling or referral service.		
		The Contractor shall not prohibit or restrict a Provider from advising a beneficiary about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.		
		If the Contractor is unable to provide necessary medical services covered under this Contract, it shall timely and adequately cover these services out of network for the Member for as long as Contractor is unable to provide them. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will use its best efforts to ensure that cost to the Member is no greater than it would be if the services were provided within the Contractor's Network.		
		DMS will provide written advance notice to PHP regarding any changes in the fee schedule, expansion or reduction of covered services and benefit limitations.		
8.1.1	96	**Emergency Care**		
		Emergency Care must be available to Members 24 hours a day, seven days a week. Urgent Care services by any Provider in the Partnership's Program shall be made available within 48 hours of request. Post Stabilization Care services are covered and paid for in accordance with 42 CFR 422.113(c) and 438.114(c).		
8.1.2	96	**Out of Network Emergency Care**		
		The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Partnership Region, in accordance with 42 CFR 431.52 and 907 KAR 1:084. These regulations require that the Commonwealth, including Department and its Contractor, cover not only Medically Necessary services due to a medical emergency, but also out-of-state medical services if any of the following conditions is met:		
		(a) Medical services are needed and the member's health would be endangered if he/she were required to travel to his/her state of residence;		
		(b) The Contractor determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in other states; or		
		(c) It is the general practice for Recipients in a particular locality to use medical resources in another state.		
		Emergency Services covered by a non-contracting provider shall not exceed the fee-for service rate as required by Section 6085 of the Deficit Reduction Act of 2005.		
		Reporting and Data Requirements		
10	117	The Contractor shall provide to the Department managerial, financial, delegation, utilization, quality, and enrollment reports. The parties acknowledge that CMS has requested Department to provide certain reports concerning Contractor. Contractor agrees to provide Department with the reports CMS has requested or does request. Additionally, the parties agree for Contractor to provide any additional reports requested by Department upon mutual agreement of the parties. The parties agree that Attachment X may be amended outside the scope of this agreement The Department may require the Contractor to prepare and submit adhoc reports.		
		The Contractor shall respond to any Department request for information or documents, within the timeframe specified by the Department in its request. In the event the Contractor is unable to respond within the specified timeframe, the Contractor shall immediately notify the Department in writing and shall include an explanation for the inability to meet the timeframe and a request for approval of an extension of time. The Department may approve within, it sole discretion, any such extension of time upon a showing of good cause by the Contractor. To avoid delayed responses by Contractor caused by a high volume of information or document requests by the Department, the Parties shall devise and agree upon a functional method of prioritizing requests so that urgent requests are given appropriate priority.	Not included	Not included
10.1	117	**Record System Requirements**		
		The Contractor shall maintain or cause to be maintained detailed records relating to the operation of the Contractor's Partnership Program, including but not limited to the following:		
		(a) The administrative costs and expenses incurred pursuant to this Contract;		
		(b) Member enrollment status;		
		(c) Provision of Covered Services;		
		(d) All relevant medical information relating to individual Members for the purpose of audit, evaluation or investigation by the Department, the Office of Inspector General, the Attorney General and other authorized federal or state personnel;		
		(e) Quality Improvement and utilization;		

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		(f) All financial records, including all financial reports required under Section 10.6 of this Contract **and A/R activity, rebate data, DSH requests and etc**	Bold not included	Bold not included
		(g) Performance reports to indicate Contractor's compliance with contract requirements;	Not included	Not included
		(h) Fraud and abuse; and		
		(i) Managerial reports.		
		All records shall be maintained and available for review by authorized federal and state personnel during the entire term of this Contract and for a period of five (5) years after termination of this Contract, except that when an audit has been conducted, or audit findings are unresolved. In such case records shall be kept for a period of five (5) years in accordance with 907 KAR 1:672 or until all issues are finally resolved, whichever is later.		
10.2	118	**Reporting Requirements and Standards**		
		Reports submitted by the Contractor shall meet certain standards:		
		(a) The Contractor shall verify the accuracy for data and other information on reports submitted		
		(b) Reports or other required data shall be received on or before scheduled due dates		
		(c) Reports or other required data shall conform to the Department's defined standards and		
		(d) All required information shall be fully disclosed in a manner that is responsive and without material omission		
		The Contractor shall analyze all required reports internally before submitting to the Department. The Contractor shall analyze the reports for any early patterns of change, identified trends, or outliers and shall submit this analysis with the required report. The Contractor shall submit a written narrative with the report documenting the Contractor's interpretation of the early patterns of change, identified trend or outlier.		
		The submission of late, inaccurate or otherwise incomplete reports shall be considered failure to report. Sanctions may be imposed by the Department for failure to submit accurate and timely reports.		
		The Contractor shall be responsible for complying with the reporting requirements set forth in this Contract. The Contractor shall be responsible for assuring the accuracy, completeness and timely submission of each report. Reports shall be submitted in electronic format, paper or disk. The Contractor shall provide such additional data and reports as may be reasonably requested by the Department. The Department shall furnish the Contractor with the appropriate reporting formats, instructions, timetables for submission and such technical assistance in filing reports and data as may be permitted by the Department's available resources. The Department reserves the right to modify from time to time the form, nature, content, instructions and timetables for the collection and reporting of data. Any requested modification will take cost into consideration.		
		If the Contractor and the Department are in agreement, the reporting requirements outlined in **Attachment X** and Attachment XI may be amended with a written agreement.	Bold not included	Bold not included
10.3	119	**Enrollment Reports**		
		The Contractor shall review each Member Listing Report upon receipt and shall submit all corrections to the Department within forty-five (45) days of the Member Listing Report. Corrections missed during this initial period must be submitted within four (4) months of identification of the error. Adjustments shall be made to the next Member Listing Report to reflect corrections, and the Enrollment or Disenrollment of Members reported to the Department (and approved by the Department in case of voluntary Disenrollment for cause) by the Contractor once the corrections are received by the Department.		
10.4	119	**EPSDT Reports**		
		The Contractor shall submit Encounter Record to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter Record shall be completed according to the requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Annually the Contractor shall submit a report on EPSDT activities, utilization and services and the current Form CMS-416 to the Department.		
10.5	119	**Management Reports**		
		Managerial reports demonstrate compliance with operational requirements of the contract. These reports shall include, but not be limited to, information on such topics as:		
		(a) Composition of current provider networks and capacity to take on new Medicaid members		
		(b) Changes in the composition and capacity of the provider network		
		(c) PCP to Member ratio		
		(d) Identification of TPL		
		(e) Grievance and appeals resolution activities		
		(f) Fraud and abuse activities		
		(g) Delegation oversight activities and		
		(h) Member satisfaction.		
10.6	120	**Financial Reports**		
		Financial reports demonstrate the Contractor's ability to meet its' commitments under the terms of this contract. The Contractor and its subcontractors shall maintain their accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted system of accounting. The accounting system shall clearly document all financial transactions between the Contractor and its subcontractors and the Contractor and the Department. These transactions shall include, but not be limited to, claims payment, refunds and adjustment of payments.		
		The Contractor shall file, within one hundred seventy five days (175) days following the end of each fiscal year, annual audited financial statements as of the end of such fiscal year, prepared by an independent Certified Public Accountant on an accrual basis, in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants.		
		The Contractor shall also file, within seventy-five (75) days following the end of each fiscal year, certified copies of the annual statement and reports as prescribed and adopted by the OOI.		
		The Contractor shall file within sixty (60) days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the National Association of Insurance Commissioners.		

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		The Contractor shall file with the Department, within seven (7) days after issuance, a true, correct and complete copy of any report or notice issued in connection with a financial examination conducted by or on behalf of the OOI.		
10.7	120	**Ownership and Financial Disclosure**		
		The Contractor agrees to comply with the provisions of 42 CFR 455.104, notwithstanding the fact that such provisions may not be applicable to the Contractor. The Contractor shall provide true and complete disclosures of the following information to the Department, CMS, and/or their agents or designees, in a form designated by the Department (1) at the time of each annual audit, (2) at the time of each Medicaid survey, (3) prior to entry into a new contract with the Department, (4) upon any change in operations which affects the most recent disclosure report, or (5) within thirty-five (35) days following the date of each written request for such information:	Bold not included	Bold not included
		(a) The name and address of each person with an ownership or control interest in (i) the Contractor or (ii) any Subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons who are related as spouse, parent, child, or sibling;		
		(b) The name of any other entity receiving reimbursement through the Medicare or Medicaid programs in which a person listed in response to subsection (a) has an ownership or control interest;		
		(c) The same information requested in subsections (a) and (b) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than $25,000 during the immediately preceding twelve-month period;		
		(d) A description of any significant business transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five year period;		
		(e) The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs;		
		(f) The name of any officer, director, employee or agent of, or any person with an ownership or controlling interest in, the Contractor, any Subcontractor or supplier, who is also employed by the Commonwealth or any of its agencies and		
		(g) The Contractor shall be required to notify the Department immediately when any change in ownership is anticipated. The Contractor shall submit a detailed work plan to the Department and to the DOI during the transition period no later than the date of the sale, that identifies areas of the contract that may be impacted by the change in ownership, including management and staff.		
10.8	121	**Utilization and Quality Improvement Reporting**		
		Utilization and Quality Improvement reports demonstrate compliance with the Departments service delivery and quality standards. These reports shall include, but not be limited to:		
		(a) Trending and analysis reports on areas such as quality of care, access to care, or service delivery access		
		(b) Encounter data as specified by the Department		
		(c) Utilization review and management activities data and		
		(d) Other required reports as determined by the Department, including, but not limited to, performance and tracking measures		
10.9	121	**Access to Records**		
		The Contractor and any Subcontractor shall make all of its books, documents, papers, provider records, Medical Records, data, surveys and computer databases (collectively "Records") available for examination and audit by the Department, the Attorney General of the Commonwealth of Kentucky, the OOI, authorized federal or Commonwealth personnel, or the authorized representatives of the governments of the United States and the Commonwealth of Kentucky including, without limitation, any employee, agent, or subcontractor of the Department, Cabinet for Health and Family Services, CMS, or the Department's Fiscal Agent.		
		Access shall be at the discretion of the requesting authority and shall be either through on-site review of records or by submission of records to the office of the requesting authority. Any records requested pursuant to this Contract should be produced immediately for on-site reviews or sent to the requesting authority by mail within fourteen (14) days following a request. All records shall be provided at the sole cost and expense of the Contractor or Subcontractor including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping and/or mailing of records. The Department shall have unlimited rights to use, disclose, and duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Contractor or Subcontractor and in any way relating to this Contract.		
11	123	**Program Integrity**		
		The Contractor shall develop in accordance with Attachment VII, a Program Integrity plan concerning the establishment of internal controls, policies and procedures that are capable of preventing, detecting and deterring incidents of Fraud, **Waste** and Abuse. The **required** procedures shall include the following **and be made available for review by the Department**:	Bold not included	Bold not included
		(a) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;		
		(b) The designation of a compliance officer and a compliance committee that are accountable to senior management;		
		(c) Effective education for the compliance officer, the organization's employees, subcontractors, providers and members **regarding fraud, waste and abuse;**	Bold not included	Bold not included
		(d) Effective lines of communication between the compliance officer and the organization's employees;		
		(e) Enforcement of standards through disciplinary guidelines;		
		(f) Provision for internal monitoring and auditing **of the member and provider;**	Bold not included	Bold not included
		(g) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;.		
		(h) Provision for internal monitoring and auditing of Contractor and its subcontractors; and supply the department with quarterly reports on the activity;	Not included	Not included
		(i) Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;	Not included	Not included
		(j) Contractor shall create an account receivables process to collect outstanding debt from members or providers; and provide monthly reports of activity and collections to the department;	Not included	Not included
		(k) Contractor shall provide procedures for appeal process;	Not included	Not included
		(l) Contractor shall comply with the expectations of 42 CFR 455.20 (a) by employing a method of verifying with recipients whether the services billed by provider were received;	Not included	Not included
		(m) Contractor shall create a process for card sharing cases;	Not included	Not included
		(n) Contractor shall follow cases from the time they are opened until they are closed; and	Not included	Not included

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		(o) Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.	Not included	Not included
		Rate Component		
12.1	124	**Rate Proposals**		
		The Department shall use its best efforts to commence negotiations with the Contractor for the next term of the Agreement, within ninety (90) days prior to the expiration of the current term, and propose rates at least thirty (30) days prior to the expiration of the current term, unless the Department elects to terminate the Agreement hereunder.		
12.2	124	**Rate Methodology**		
		The Department's actuary shall submit a narrative description of the rate methodology used in determining the rate proposals.		
12.3	124	**Actuarial Certification**		
		The Department shall submit an actuarial certification for all rate proposals in accordance with all applicable laws.		
		Functions and Duties of the Department		
13.4	125	**Contractor Review of Study or Audit Results**		
		The Department shall submit for the Contractor's review any studies or audits to be released to the public that refer to or reflect the Contractor's participation in the Partnership Program. The Contractor shall have thirty (30) days from receipt of any such study or audit to provide the Department with comments. Nothing in this subsection shall be deemed to (1) limit the Department's absolute right to release to the public any study or review which the Department, in its sole discretion, deems appropriate, or (2) require the Contractor's approval of the release of any information to the public, in accordance with federal and Commonwealth law.		
13.5	125	**Organizational Documents**		
		The Department shall submit to the Contractor upon any material changes, and at such other times as the Contractor may request, a current organizational chart showing basic functions and number of employees for those functions, and a list of key managers in the Department and in the Department's designee organization for any of the Department's obligations under this Contract, who are persons responsible for the basic functions of the organization.		
		Remedies for Violations, Breach, or NonPerformance of Contract		
14.1	126	**Requirement of Corrective Action**		
		The Department may require corrective action in the event that any report, filing, examination, audit, survey, inspection, or investigation should indicate that the Contractor, or any Subcontractor or supplier is not in compliance with any provision of this Contract, or in the event that the Department receives a substantiated Grievance or Appeal respecting the standard of care rendered by the Contractor, or any Subcontractor or supplier. The Department may also require the modification of any policies or procedures of the Contractor relating to the fulfillment of its obligations pursuant to this Contract. Should the Department desire to take any such corrective action it must issue a written deficiency notice and require a corrective action plan to be filed by the Contractor within fifteen (15) days following the date of the notice. A corrective action plan shall delineate the time and manner in which each deficiency is to be corrected. The plan shall be subject to approval by the Department, which may acovision (907 KAR Chapter 1 and 907 KAR 3:005) and individual Medicaid program services manuals incorporated by reference in the administrative regulations. □□		
14.3	127	**Health Care Data Sanctions**		
		If the Contractor knowingly fails to submit health care data derived from processed claims or Encounter data in the required form or format required by the terms of this Contract or information/data from processed claims otherwise specified by the Department pursuant to this Contract, the Department may withhold an amount commensurate with harm but not to exceed ten (10%) percent of the Contractor's Capitation Payment for the month following non-submission of data. The Department shall retain the amount withheld until the data is received and accepted by the Department. Any other health care information/data requested by the Department or required pursuant to this Contract, including social and demographic data, shall be submitted to the Department in accordance with the time-frames developed by the Department which shall take into consideration the purpose for the data requested, the availability of information, the capabilities of the Contractor to collect and assemble the data in readable form and the cosov		
14.4	127	**Intermediate Sanction and Civil Money Penalties**		
		In the event the Contractor fails to comply with the terms and conditions of 42 United States Code Section 1396b(m), the Department may do any of the following:		
		(a) Appoint temporary management to oversee the entity if a plan engages in continued egregious behavior or there is a substantial risk to the health of enrollees;		
		(b) Permit individuals to disenroll without cause;		
		(c) Suspend default Enrollment; or		
		(d) Suspend payment for new enrollees.		
		Prior to imposing the intermediate sanctions, the Department must give the Contractor timely written notice that explains the basis and nature of the sanction and any other due process protections that the Department elects to provide.		
		Before terminating the Contract under 42 CFR 438.708, the Department must provide the Contractor with a pre-termination hearing. The State shall give the Contractor written notice of its intent to terminate, the reason for termination, and the time and place of hearing. The Department shall give the Contractor, after the hearing, written notice of the decision affirming or reversing the proposed termination of the Contract, and for an affirming decision, the effective date of termination. For an affirming decision, the Department shall give Members notice of the termination and information, consistent with 42 CFR 438.10 on their options for receiving Medicaid services following the effective date of termination.		
		The Department may impose civil money penalties in the circumstances and the amounts set forth below if the Contractor does any of the following:		
		(a) Fails substantially to provide Medically Necessary items and services that are required under law and under this Contract ($25,000);		
		(b) Imposes excess premiums and charges; (doubles the excess amount charged);		
		(c) Acts to discriminate among Members; (an amount not to exceed $100,00;		
		(d) Misrepresents or falsifies information; (an amount not to exceed $100,000); or		
		(e) Violates marketing guidelines ($10,000).		
14.6	128	**Termination for Cause**		

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		In addition to nonperformance of the particular terms and conditions of this Contract by the Contractor, each of the following shall constitute breach of the Contract by Contractor for which any of the remedies set forth in the Contract are available to the Department, as well as a remedy of immediate termination of this Contract if the problem is not cured in the time frame specified by the Department:		
		(a) The conduct of the Contractor, any Subcontractor or supplier, or the standard of services provided by or on behalf of the Contractor, fails to meet the Department's minimum standards of care or threatens to place the health or safety of any group of Members in jeopardy;		
		(b) The Contractor is either expelled or suspended from the federal health insurance programs under Title XVIII or Title XIX of the Social Security Act;		
		(c) UHC's HMO license to operate as an HMO is suspended or terminated by the OOI, or any adverse action is taken by the OOI which is deemed by the Department to affect the ability of the Contractor to provide health care services as set forth in this Contract to Members;		
		(d) The Contractor fails to maintain protection against fiscal insolvency as required under state or federal law, or as required by the terms of this Contract, or the Contractor fails to meet its financial obligations as they become due other than with respect to contested or challenged claims filed by Members or Providers;		
		(e) The Contractor fails to or knowingly permits any Subcontractor, supplier, or any other person or entity who receives compensation pursuant to performance of this Contract, to fail to comply with the nondiscrimination and affirmative action requirements of Section 1.4.4 of this Contract;		
		(f) The Contractor provides or knowingly permits any Subcontractor to provide fraudulent, or intentionally misleading or misrepresentative information to any Member, or to any agent of the Commonwealth or the United States in connection with the Partnership Program; or		
		(g) Gratuities other than de-minimus or otherwise legal gratuities are offered to, or received by, any public official, employee or agent of the Commonwealth from the Contractor, its agent's employees, Subcontractors or suppliers, in violation of Section 17.2 of this Contract.		
		In addition to any of the types of breach specified in this Contract, if either of the sources of reimbursement for medical assistance, Commonwealth and federal appropriations no longer exists, or in the event that the sum of all obligations of the Department incurred pursuant to this Contract and all other contracts entered into by the Department, including without limitation, all Contracts with Providers entered into pursuant to the Partnership Program, equals or exceeds the balance of such sources available to the Department for "Medical Assistance Benefits" for the fiscal year in which this Contract is effective, less one hundred dollars ($100.00), then this Contract shall immediately terminate without further obligation of the Department as of that event; provided, however that the Department shall provide Contractor with reasonable advance notice of facts likely to result in such event.		
		As part of the Department's option to terminate, if the Contractor is in uncured material breach of the Contract or is insolvent, the Department has the option to assume the rights and obligations of the Contractor and directly operate the Partnership Program, using the existing Partnership administrative organization, to ensure delivery of care to Members through the Contractor's Network until cure by the Contractor of the breach or by demonstrated financial solvency, or until the successful transition of those Members to Fee for Service Medicaid providers at the expense of the Contractor.		
		The certification by the Commissioner of the Department of the occurrence of any of the events stated above shall be conclusive. The Contractor, however, shall retain all rights to dispute resolution specified in Section 17.8 of this Contract.		
14.7	130	**Obligations upon Termination**		
		Upon termination of this Contract by the Department for convenience or for cause, the Contractor shall be solely responsible for the provision and payment for all Covered Services for all Members for the remainder of any month for which the Department has paid the monthly Capitation Rate. Upon final notice of termination, on the date, and to the extent specified in the notice of termination, the Contractor shall:		
		(a) Continue providing Covered Services to all Members until midnight on the last day of the calendar month for which a Capitation Payment has been made by the Department;		
		(b) Continue providing all Covered Services to all infants of female Members who have not been discharged from the hospital following birth, until each infant is discharged, or for the period specified in (a) above, whichever period is shorter;		
		(c) Continue providing inpatient hospital services to any Members who are hospitalized on the termination date, until each Member is discharged, or for the period specified in (a) above, whichever period is shorter;		
		(d) Arrange for the transfer of Members and Medical Records to other appropriate Providers;		
		(e) Promptly supply to the Department such information as it may request respecting any unpaid claims submitted by Out of Network Providers and arrange for the payment of such claims within the time periods provided herein;		
		(f) Take such action as may be necessary, or as the Department may direct, for the protection of property related to this Contract, which is in the possession of the Contractor and in which the Department has or may acquire an interest; and		
		(g)Provide for the maintenance of all records for audit and inspection by the Department, CMS and other authorized government officials, in accordance with terms and conditions specified in this Contract including the transfer of all such data and records, or copies thereof, to the Department or its agents as may be requested by the Department; and the preparation and delivery of any reports, forms or other documents to the Department as may be required pursuant to this Contract or any applicable policies and procedures of the Department.		
		The covenants set forth in this Section shall survive the termination of this Contract and shall remain fully enforceable by the Department against the Contractor. In the event that the Contractor fails to fulfill each covenant set forth in this Section, the Department shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such covenants, all at the sole cost and expense of the Contractor and the Contractor shall refund to the Department all sums expended by the Department in so doing.		
		After the State notifies the Contractor that it intends to terminate the Contract, the State may provide the Member written notice of the State's intent to terminate the Contract and allow the Members to disenroll immediately without cause.		
14.8	131	**Liquidated Damages**		
		The Contractor and the Department acknowledge and agree that each has incurred substantial expense in connection with the preparation and entry into this Contract, including expenses related to training of staff, data collection and processing, actuarial determination of Capitation Rates for the initial term and each renewal term, and ongoing changes to the Medicaid Management Information System ("MMIS") operated by the Department. The Contractor and the Department further acknowledge and agree that in the event this Contract is terminated prior to the end of the term, the non-terminating party will incur substantial additional expenses and costs which are difficult or impossible to accurately estimate.		
		Based upon the foregoing, the Contractor and the Department have agreed as follows:		

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		(a) To provide for the payment by the Contractor to the Department of liquidated damages equal to five percent (5%) of the maximum monthly Capitation Payment each month until the Department elects to administer the program or replace the Contractor for a period not to exceed six (6) months, plus $2,500,000 if this Contract is terminated for cause, as specified in Section 14.6 of this Contract.		
		The Contractor and the Department have agreed to provide for payment to the Contractor by the Department of liquidated damages equal to $2,500,000 if this Contract is terminated by the Department for convenience as specified in Section 14.5 of this Contract.		
		In either case, such payment is to be made no later than thirty (30) days following the date of the notice of termination. The Department and the Contractor agree that the sum set forth herein as liquidated damages is a reasonable pre-estimate of the probable loss which will be incurred by the Department in the event this Contract is terminated prior to the end of the Contract term.		
		(b) In the event that this Contract is terminated by the Department for convenience, as contemplated by 200 KAR 5:312 Section 2, the Contractor shall be entitled to recover certain costs as set forth above.		
		Notwithstanding any other provision to the contrary, the Contractor and the Department agree that the Contractor is entitled to liquidated damages in the event that the Department fails to pay the Capitation Payment, fails to continue enrollment of all eligible groups as specified in the Contract, or other such failure by the Commonwealth that causes the Contractor to be unable to administer the Partnership Program.		
		Upon the occurrence of any of the above, the Contractor shall notify the Department of its determination and of the facts and circumstances that support that determination. The Contractor shall provide the Department with the opportunity to cure the failure in accordance with the provisions of Section 14.1 of this Contract. Upon failure to correct, the Contractor, in addition to the remedy of immediate termination of the Contract, shall be entitled to an amount equal to the reasonable costs incurred for closing the Partnership Program but not to exceed two million five hundred thousand dollars ($2,500,000).		
16	133	**Confidentiality of Records**		
		The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 C.F.R. Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 17.11.		
		The Contractor shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home.		
		The Contractor, as well as all employees, agents and assigns of the Contractor, shall sign a confidentiality agreement.		
		Except as otherwise required by law, regulations, or this Contract, access to such information shall be limited by the Contractor and the Department, to persons who or agencies which require the information in order to perform their duties related to the administration of the Department, including but not limited to the U.S. Department of Health and Human Services, U.S. Attorney's Office the Office of the Inspector General, the Attorney General, and such others as may be required by the Department.		
		Any data, information, records or reports which may be disclosed to the Department by the Contractor pursuant to the express terms of this Contract shall not be disclosed or divulged by the Department in whole or in part to any other third person, other than expressly provided for in this Contract, or the Kentucky Open Records Act, KRS 61.870-61.882. The Department and the Contractor agree that this confidentiality provision will survive the termination of this Contract.		
		Proprietary information, which consists of data, information or records relating to the Contractor, its affiliates' or subsidiaries' business operations and structure, sales methods, practices and techniques, advertising, methods and practices, provider relationships unless otherwise expressly provided for in this Contract, non-Medicaid member or enrollee lists, trade secrets, and the Contractor's, its affiliates' or subsidiaries' relationships with its suppliers, providers, potential members or enrollees and potential providers, is supplied under the terms of this Contract based on the Department's representation that the information is not subject to disclosure, except as otherwise provided by the Kentucky Open Records Act, KRS 61.870-61.882 or 200 KAR 5:314. The Contractor understands that it must designate information it has which it considers proprietary for review by the Finance and Administration Cabinet to be sure it meets the definition of proprietary information exempt from disclosure at KRS 61.878(ovisio		
		Any requests for disclosure of information received by the Contractor pursuant to this section of the Contract shall be submitted to and received by the Department's Contract Compliance Officer within twenty-four (24) hours as specified in Section 17.12 of this Contract, and no information shall be disclosed pursuant to such a request without prior written authorization from the Department.		
		Miscellaneous		
17.1	134	**Conflict of Interest**		
		By the signature of its authorized representative, the Contractor certifies that it is legally entitled to enter into this Contract with the Commonwealth, and in holding and performing this Contract, the Contractor does not and will not violate either applicable conflict of interest statutes (KRS 45A.330‑45A.340, 45A.990, 164.390), or KRS 11A.040 of the Executive Branch Code of Ethics, relating to the employment of former public servants.		
17.2	134	**Offer of Gratuities / Purchasing and Specifications**		
		The Contractor certifies that no member or delegate of Congress, nor any elected or appointed official, employee or agent of the Commonwealth, the Kentucky Cabinet for Health and Family Services, CMS, or any other federal agency, has or will benefit financially or materially from this procurement. This Contract may be terminated by the Department pursuant to Section 14.6 herein if it is determined that gratuities were offered to or received by any of the aforementioned officials or employees from the Contractor, its agents, employees, Subcontractors or suppliers.		
		The Contractor certifies by its signatories hereinafter that it will not attempt in any manner to influence any specifications to be restrictive in any way or respect or will it attempt in any way to influence any purchasing of services, commodities or equipment by the Commonwealth. For the purpose of this paragraph, "it" is construed to mean any person with an interest therein, as required by applicable law.		
17.3	135	**Independent Capacity of the Contractor and Subcontractors**		
		It is expressly agreed that the Contractor and any Subcontractors and agents, officers, and employees of the Contractor or any Subcontractors shall act in an independent capacity in the performance of this Contract and not as officers or employees of the Department or the Commonwealth. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the Contractor or any Subcontractor and the Department or the Commonwealth.		
17.4	135	**Assignment**		

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		Except as allowed through Subcontracting, this Contract and any payments that may become due hereunder, shall not be assignable by the Contractor, either in whole or in part, except with the prior written approval of the Department. The transfer of five percent (5%) or more of the beneficial ownership in the Contractor at any time during the term of this Contract shall be deemed an assignment of this Contract. The Department shall be entitled to assign this Contract to any other agency of the Commonwealth which may assume the duties or responsibilities of the Department relating to this Contract. The Department shall provide written notice of any such assignment to the Contractor, whereupon the Department shall be discharged from any further obligation or liability under this Contract arising on or after the date of such assignment.		
17.11	137	**Health Insurance Portability and Accountability Act**		
		The Contractor agrees to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Any Subcontract entered by the Contractor as a result of this agreement shall mandate that the Subcontractor be required to abide by the same statutes and regulations regarding confidentiality of protected health information as is the Contractor.		
17.14	138	**Urban Trauma center Payment**		
		In order to allow for the inclusion of the Urban Trauma Center payment in the scope of this contract, the contractor shall agree that payment of this pass-through amount is contingent upon the Commonwealth's receipt of the necessary state matching funds to support such payment and shall so do in a manner necessary to meet all federal requirements governing such transactions. The Commonwealth and the Contractor agree that should the Commonwealth encounter difficulties in obtaining federal approval of this transaction, the parties will renegotiate in relation to this specific contractual item.	Not included	Not included
Contract Addendum	139	The undersigned hereby certifies that neither he/she nor any member of his/her immediate family having an interest of 10% or more in any business entity involved in the performance of this Contract or has contributed more than the amount specified in KRS 121.056(2) to the campaign of the gubernatorial candidate elected at the election last preceding the date of this Contract. The undersigned further swears under the penalty or perjury, that neither he/she nor the Company which he/she represents, has knowingly violated any provisions of the campaign finance laws of the Commonwealth, and that the award of a Contract to him/her or the Company which he/she represents will not violate any provisions of the campaign finance laws of the Commonwealth.		
Contract Addendum	140	The undersigned hereby certifies that neither he/she nor any member of his/her immediate family having an interest of 10% or more in any business entity involved in the performance of this Contract or has contributed more than the amount specified in KRS 121.056(2) to the campaign of the gubernatorial candidate elected at the election last preceding the date of this Contract. The undersigned further swears under the penalty or perjury, that neither he/she nor the Company which he/she represents, has knowingly violated any provisions of the campaign finance laws of the Commonwealth, and that the award of a Contract to him/her or the Company which he/she represents will not violate any provisions of the campaign finance laws of the Commonwealth.		
Contract Addendum	141	The undersigned hereby certifies that neither he/she nor any member of his/her immediate family having an interest of 10% or more in any business entity involved in the performance of this Contract or has contributed more than the amount specified in KRS 121.056(2) to the campaign of the gubernatorial candidate elected at the election last preceding the date of this Contract. The undersigned further swears under the penalty or perjury, that neither he/she nor the Company which he/she represents, has knowingly violated any provisions of the campaign finance laws of the Commonwealth, and that the award of a Contract to him/her or the Company which he/she represents will not violate any provisions of the campaign finance laws of the Commonwealth.		
		Attachments		
Attachment I	141	**THIRD PARTY PAYMENTS/COORDINATION OF BENEFITS**		
		I. To meet the requirements of 42 CFR 433.138 through 433.139, the Contractor shall be responsible for:		
		A.) Maintaining an MIS that includes:		
		1.) Third Party Liability Resource File		
		Policy Begin Date		
		Policy End Date		
		Policyholder Name		
		Policyholder Address		
		Insurance Company Name		
		Insurance Company Address		
		Type of Coverage		
		Policy Type		
		HIC Number		
		(a) Cost Avoidance		
		Use automated daily and monthly TPL files to update the Contractor's MIS TPL files as appropriate. This information is to cost avoid claims for members who have other insurance.		
		At a later date, DMS may require the Contractor to obtain subscriber data and perform data matches directly with a specified list of insurance companies, as defined by DMS.		
		(b) Department for Community Based Services (DCBS)		
		Apply Third Party Liability (TPL) information provided electronically on a daily basis by DMS through its contract with DCBS to have eligibility caseworkers collect third party liability information during the Recipient application process and reinvestigation process.		
		(c) Workers' Compensation		
		The TPL vendor performs this function. The date is provided electronically on a daily and monthly basis. This data should be applied to TPL files referenced in I.A.1.a (Commercial Data Matching) in this Attachment.		
		2.) Third Party Liability Billing File		
		MAID		
		TCN		
		Policy#		
		Carrier Billed		
		Amount Paid		

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		Amount Billed		
		Amount Received		
		TCN Status Code (Code identifies if claim was denied and the reason for the denial)		
		Billing Type (Code identifies claim was billed to insurance policy)		
		Date Billed		
		Date Paid or Denied		
		Date Rebilled		
		(a) Commercial Insurance/Medicare Part B Billing		
		The Contractor's MIS should automatically search paid claim history and recover from providers, insurance companies or Medicare Part B in a nationally accepted billing format for all claim types whenever other commercial insurance or Medicare Part B coverage is discovered and added to the Contractor's MIS that was unknown to the Contractor at the time of payment of a claim or when a claim could not be cost avoided due to federal regulations (pay and chase) which should have been paid by the health plan. Within sixty (60) Days from the date of identification of the other third party resource billings must be generated and sent to liable parties		
		(b) Medicare Part A		
		The Contractor's MIS should automatically search paid claim history and generate reports by Provider of the billings applicable to Medicare Part A coverage whenever Medicare Part A coverage is discovered and added to the Contractor's MIS that was unknown to the Contractor at the time of payment of a claim. Providers who do not dispute the Medicare coverage should be instructed to bill Medicare immediately. The Contractor's MIS should recoup the previous payment from the Provider within sixty (60) days from the date the reports are sent to the Providers, if they do not dispute that Medicare coverage exists.		
		(b) Manual Research/System Billing		
		System should include capability for the manual setup for billings applicable to workers' compensation, casualty, absent parents and other liability coverages that require manual research to determine payable claims.		
		3.) Questionnaire File		
		MAID		
		Where it was sent		
		Type of Questionnaire Sent		
		Date Sent		
		Date Followed Up		
		Actions Taken		
		All questionnaires should be tracked in a Questionnaire history file on the MIS.		
		B.) Coordination of Third Party Information (COB)		
		1.) Division of Child Support Enforcement (DCSE)		
		Provide county attorneys and the Division of Child Support Enforcement (DCSE) upon request with amounts paid by the Contractor in order to seek restitution for the payment of past medical bills and to obtain insurance coverage to cost avoid payment of future medical bills.		
		2.) Casualty Recoveries		
		Provide the necessary information regarding paid claims in order to seek recovery from liable parties in legal actions involving Members.		
		Notify DMS with information regarding casualty or liability insurance (i.e. auto, homeowner's, malpractice insurance, etc.) when lawsuits are filed and attorneys are retained as a result of tort action. This information should be referred in writing within five (5) working Days of identifying such information.		
		In cases where an attorney has been retained, a lawsuit filed or a lump sum settlement offer is made, the Contractor shall notify Medicaid within five days of identifying such information so that recovery efforts can be coordinated.		
		C.) Claims		
		1.) Processing		
		a.) Contractor MIS edits:		
		Edit and cost avoid Claims when Member has Medicare coverage;		
		Edit and cost avoid Claims when Provider indicates other insurance on claim but does not identify payment or denial from third party;		
		Edit and cost avoid Claims when Provider indicates services provided were work related and does not indicate denial from workers' compensation carrier;		
		Edit and cost avoid or pay and chase as required by federal regulations when Member has other insurance coverage. When cost avoiding the Contractor MIS should supply the Provider with information on the remittance advice that would be needed to bill the other insurance such as carrier name, address, policy #, etc.;		
		Edit Claims as required by federal regulations for accident/trauma diagnosis codes. Claims with the accident/trauma diagnosis codes should be flagged and accumulated for ninety (90) Days and if the amount accumulated exceeds $250 a questionnaire should be sent to the Member in an effort to identify whether other third party resources may be liable to pay for these medical bills;		
		Contractor is prohibited from cost avoiding Claims when the source of the insurance coverage was due to a court order. All Claims with the exception of hospital Claims must be paid and chased. Hospital claims may be cost avoided; and		
		Questionnaire should be generated and mailed to Members and/or Providers for claims processed with other insurance coverage indicated on the claim and where no insurance coverage is indicated on the Contractor's MIS Third Party Files.		
		2.) Encounter Record		
		a.) TPL Indicator		
		b.) TPL Payment		
		II. DMS shall be responsible for the following		
		1. Provide the Contractor with an initial third party information tape;		
		2. Provide copies of insurance company's computerized subscriber eligibility files that are received by DMS;		
		3. Provide electronic computerized files of third party information transmitted from DCBS;		
		4. Provide the Contractor with copy of the tape received form the Labor Cabinet on a quarterly basis;		

Contract Reference	Page #	SFY 2011 Contract Language	SFY 2010	SFY 2009
		5. Provide the Contractor with a list of the Division of Child Support Contracting Officials.		
		6. Refer calls from attorneys to the Contractor in order for their Claims to be included in casualty settlements; and		
		7. Monitoring Encounter Claims and reports submitted by the Contractor to ensure that the Contractor performs all required activities.		
Attachment II	145	**MANAGEMENT INFORMATION SYSTEMS (MIS)**		
		As specified in Section 4.0 in the Contract, The Contractor's MIS must enable the Contractor to provide format and file specifications for all data elements as specified below for all of the required seven subsystems.		
		1.) Recipient Function		
		a.) Inputs		
		The Recipient Data Maintenance function will accept input from various sources to add, change, or close records on the file(s). Inputs to the Recipient Data Maintenance function include:		
		1.) Daily and monthly electronic member eligibility updates		
		2.) Health status information		
		3.) Social demographic information		
		b.) Processing Requirements		
		The Recipient Data Maintenance function must include the following capabilities:		
		1.) Accept a daily/monthly member eligibility file from the Department in a specified format.		
		2.) Transmit a file of health status information to the Department in a specified format.		
		3.) Transmit a file of social demographic data to the Department in a specified format.		
		4.) Transmit a primary care provider (PCP) enrollment file to the Department in a specified format.		
		5.) Edit data transmitted from the Department for completeness and consistency, editing all data in the transaction.		
		6.) Identify potential duplicate Member records during update processing.		
		7.) Maintain on-line access to all current and historical Member information, with inquiry capability by case number, Medicaid Recipient ID number, social security number (SSN), HIC number, full name or partial name, and the ability to use other factors such as date of birth and/or county code to limit the search by name.		
		8.) Maintain identification of Member eligibility in special eligibility programs, such as hospice, etc., with effective date ranges/spans and other data required by the Department.		
		9.) Maintain current and historical date-specific managed care eligibility data for basic program eligibility, special program eligibility, and all other Member data required to support Claims processing, Prior Authorization processing, managed care processing, etc.		
		10.) Maintain and display the same values as the Department for eligibility codes and other related data.		
		11.) Produce, issue and mail a managed care ID card pursuant to the Department's approval.		
		12.) Identify Member changes in the primary care provider (PCP) and the reason(s) for those changes to include effective dates.		
		13.) Monitor PCP capacity and limitations prior to Enrollment of a Member to the PCP.		
		14.) Generate and track PCP referrals.		
		15.) Assign applicable Member to PCP if one is not selected within thirty (30) Days, except Members with SSI without Medicare, who are allowed ninety (90) Days.		
		c.) Reports		
		Reports for Member function are described in Attachment XI.		
		d.) On-line Inquiry and Update Screens		
		On-line inquiry and update screens that meet the user interface requirements of this section and provide access to the following data:		
		1.) Member basic demographic data		
		2.) Member liability data		
		3.) Member characteristics and service utilization data		
		4.) Member current and historical managed care eligibility data		
		5.) Member special program data		
		6.) Member social/demographic data		
		7.) Health status data		
		8.) PCP data		
		e.) Interfaces		
		The Member Data Maintenance function must accommodate an external interface, of CPU to CPU, with the Department.		
	146	**2.) Third Party Liability (TPL) Processing**		
		The Third Party Liability (TPL) processing function permits the Contractor to utilize the private health, Medicare, and other third-party resources of its Members and ensures that the Contractor is the payer of last resort. This function works through a combination of cost avoidance (non-payment of billed amounts for which a third party may be liable) and post-payment recovery (post-payment collection of Contractor paid amounts for which a third party is liable).		
		Cost avoidance is the preferred method for processing claims with TPL. This method is implemented automatically by the MIS through application of edits and audits which check claim information against various data fields on recipient, TPL, reference, or other MIS files. Post-payment recovery is primarily a back-up process to cost avoidance, and is also used in certain situations where cost avoidance is impractical or unallowable.		
		The TPL information maintained by the MIS must include Member TPL resource data, insurance carrier data, health plan coverage data, threshold information, and post payment recovery tracking data. The TPL processing function will assure the presence of this information for use by the Edit/Audit Processing, Financial Processing, and Claim Pricing functions, and will also use it to perform the functions described in this subsection for TPL Processing.		
		a.) Inputs		
		The following are required inputs to the TPL function of the MIS:		
		1.) Member eligibility, Medicare, and TPL, information from the Department.		
		2.) Enrollment and coverage information from private insurers/health plans, state plans, and government plans.		

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		3.) TPL-related data from claims, claim attachments, or claims history files, including but not limited to:		
		diagnosis codes, procedure codes, or other indicators suggesting trauma or accident;		
		indication that a TPL payment has been made for the claim (including Medicare);		
		indication that the Member has reported the existence of TPL to the Provider submitting the claim;		
		indication that TPL is not available for the service claimed.		
		4.) Correspondence and phone calls from Members, carriers, and Providers.		
		b.) Processing Requirements		
		The TPL processing function must include the following capabilities:		
		1.) Maintain accurate third-party resource information by Member including but not limited to:		
		Name, ID number, date of birth, SSN of eligible Member;		
		Policy number or Medicare HIC number and group number;		
		Name and address of policyholder, relationship to Member,		
		SSN of policyholder;		
		Court-ordered support indicator;		
		Employer name and tax identification number and address of policyholder;		
		Type of policy, type of coverage, and inclusive dates of coverage;		
		Date and source of TPL resource verification; and		
		Insurance carrier name and tax identification and ID.		
		2.) Provide for multiple, date-specific TPL resources (including Medicare) for each Member.		
		3.) Maintain current and historical information on third-party resources for each Member.		
		4.) Maintain third-party carrier information that includes but is not limited to:		
		Carrier name and ID		
		Corporate correspondence address and phone number		
		Claims submission address(s) and phone number		
		5.) Identify all payment costs avoided due to established TPL, as defined by the Department.		
		6.) Maintain a process to identify previously paid claims for recovery when TPL resources are identified or verified retroactively, and to initiate recovery within sixty (60) Days of the date the TPL resource is known to the Contractor.		
		7.) Maintain an automated tracking and follow-up capability for all TPL questionnaires.		
		8.) Maintain an automated tracking and follow-up capability for post payment recovery actions which applies to health insurance, casualty insurance, and all other types of recoveries, and which can track individual or group claims from the initiation of recovery efforts to closure.		
		9.) Provide for the initiation of recovery action at any point in the claim processing cycle.		
		10.) Maintain a process to adjust paid claims history for a claim when a recovery is received.		
		11.) Provide for unique identification of recovery records.		
		12.) Provide for on-line display, inquiry, and updating of recovery case records with access by claim, Member, carrier, Provider or a combination of these data elements.		
		13.) Accept, edit and update with all TPL and Medicare information received from the Department through the Member eligibility update or other TPL updates specified by the Department.		
		14.) Implement processing procedures that correctly identify and cost avoid claims having potential TPL, and flag claims for future recovery to the appropriate level of detail.		
		15.) Provide verified Member TPL resource information generated from data matches and claims, to the Department for Medicaid Services, in an agreed upon format and media, on a quarterly basis.		
		c.) Reports		
		The following types of reports must be available from the TPL Processing function by the last day of the month for the previous month:		
		1.) Cost-avoidance summary savings reports, including Medicare but identifying it separately;		
		2.) Listings and totals of cost-avoided claims;		
		3.) Listings and totals of third-party resources utilized;		
		4.) Reports of amounts billed and collected, current and historical, from the TPL recovery tracking system, by carrier and Member;		
		5.) Detailed aging report for attempted recoveries by carrier and Member;		
		6.) Report on the number and amount of recoveries by type; for example, fraud collections, private insurance, and the like;		
		7.) Report on the unrecoverable amounts by type and reason, carrier, and other relevant data, on an aged basis and in potential dollar ranges;		
		8.) Report on the potential trauma and/or accident claims for claims that meet specified dollar threshold amounts;		
		9.) Report on services subject to potential recovery when date of death is reported;		
		10.) Unduplicated cost-avoidance reporting by program category and by type of service, with accurate totals and subtotals;		
		11.) Listings of TPL carrier coverage data;		
		12.) Audit trails of changes to TPL data.		
		d.) On-line Inquiry and Update Screens		
		On-line inquiry and update screens that meet the user interface requirements of this section and provide the following data:		
		Member current and historical TPL data		
		TPL carrier data		
		Absent parent data		
		Recovery cases		

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		Automatically generate letters/questionnaires to carriers, employers, Members, and Providers when recoveries are initiated, when TPL resource data is needed, or when accident information is required and was not supplied with the incoming claim.		
		Automatically generate claim facsimiles, which can be sent to carriers, attorneys, or other parties.		
		Provide absent parent canceled court order information generated from data matches the Division of Child Support Enforcement, to the Department, in an agreed upon format and media, on an annual basis.		
	149	**3.) Provider**		
		The provider function accepts and maintains comprehensive, current and historical information about Providers eligible to participate in the Contractor's Network. The maintenance of provider data is required to support Claims and Encounter processing, utilization/quality processing, financial processing and report functions. The Contractor will be required to electronically transmit provider enrollment information to the Department as requested.		
		a.) Inputs		
		The inputs to the provider Data Maintenance function include:		
		1.) Provider update transactions		
		2.) Licensure information, including electronic input from other governmental agencies		
		3.) Financial payment, adjustment, and accounts receivable data from the Financial Processing function.		
		b.) Processing Requirements		
		The Provider Data Maintenance function must have the capabilities to:		
		1.) Transmit a provider enrollment file to the Department in a specified format;		
		2.) Maintain current and historical provider enrollment applications from receipt to final disposition (approval only);		
		3.) Maintain on-line access to all current and historical provider information, including Provider rates and effective dates, Provider program and status codes, and summary payment data;		
		4.) Maintain on-line access to Provider information with inquiry/update by Provider name, partial name characters, provider number, SSN, FEIN, CLIA number, Provider type and specialty, County,		
		5.) Zip Code, and electronic billing status;		
		6.) Accept on-line updates to all Provider data elements;		
		7.) Edit all update data for presence, format, and consistency with other data in the update transaction;		
		8.) Edits to prevent duplicate Provider enrollment during an update transaction;		
		9.) Accept and maintain the Medicare Universal Provider Identification Number (UPIN);		
		10.) Provide a Geographic Information System (GIS) to identify Member populations, service utilization, and corresponding Provider coverage to support the Provider recruitment, enrollment, and participation;		
		11.) Maintain on-line audit trail of Provider names, Provider numbers (including old and new numbers), locations, and status changes by program;		
		12.) Identify by Provider any applicable type code, location code, practice type code, category of service code, and medical specialty and sub-specialty code which is used in the Kentucky Medicaid program, and which affects Provider billing, claim pricing, or other processing activities;		
		13.) Maintain effective dates for Provider membership, Enrollment status, restriction and on-review data, certification(s), specialty, sub-specialty, claim types, and other user-specified Provider status codes and indicators;		
		14.) Accept group provider numbers, and relate individual Providers to their groups, as well as a group to its individual member Providers, with effective date ranges/spans. A single group provider record must be able to identify an unlimited number of individuals who are associated with the group;		
		15.) Maintain multiple, provider-specific reimbursement rates, including, but not necessarily limited to, per diems, case mix, rates based on licensed levels of care, specific provider agreements, volume purchase contracts, and capitation, with beginning and ending effective dates for a minimum of sixty (60) months.		
		16.) Maintain provider-specific rates by program, type of capitation, Member program category, specific demographic classes, Covered Services, and service area for any prepaid health plan or managed care providers;		
		17.) Provide the capability to identify a Provider as a PCP and maintain an inventory of available enrollment slots;		
		18.) Identify multiple practice locations for a single provider and associate all relevant data items with the location, such as address and CLIA certification;		
		19.) Maintain multiple addresses for a Provider, including but not limited to:		
		Pay to; and		
		Service location(s).		
		20.) Create, maintain and define provider enrollment status codes with associated date spans. For example, the enrollment codes must include but not be limited to:		
		Application pending		
		Limited time-span enrollment		
		Enrollment suspended		
		Terminated-voluntary/involuntary		
		21.) Maintain a National Provider Identifier (npi);		
		22.) Maintain specific codes for restricting the services for which Providers may bill to those for which they have the proper certifications (for example, CLIA certification codes);		
		23.) Accept rate adjustments to the provider file and automatically generate all appropriate adjustments to previously paid claims without further manual intervention;		
		24.) Maintain summary-level accounts receivable and payable data in the provider file that is automatically updated after each payment cycle;		
		25.) Provide the capability to calculate and maintain separate 1099 and associated payment data by FEIN number for Providers with changes of ownership, based upon effective dates entered by the Contractor;		
		26.) Generate a file of specified providers, selected based on the Department identified parameters, in an agreed upon Department approved format and media, to be provided to the Department on an agreed upon periodic basis;		
		27.) Generate a file of provider 1099 information; and		

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		28.) Operate an automated file matching process that verifies the license/certification status of professional providers at least annually. This process shall match information from Kentucky licensing and certification entities with MIS provider file information and report on discrepancies.		
		c.) Reports – Reports for Provider functions are as described in Attachments IV and XI.		
		d.) On-line Inquiry and Update Screens		
		On-line inquiry and update screens that meet the user interface requirements of this contract and provide access to the following data:		
		1) Provider eligibility history		
		2) All rendering provider is associated, for user defined time periods		
		3) Basic information about a Provider displayed on a single screen (for example, name, location, number, program, provider type, specialty, sub-specialty, certification dates, effective dates)		
		4) Provider group inquiry, by individual provider number displaying groups and by group number displaying individuals in group		
		5) Provider rate data		
		6) Provider accounts receivable and payable data, including claims adjusted but not yet paid		
		7) Provider Medicare number(s) by Medicare number, Medicaid number, and SSN/FEIN		
		8) Demographic reports and maps from the GIS, for performing, billing, and/or enrolled provider, listing provider name, address, and telephone number to assist in the provider recruitment process and provider relations		
		9) Additional provider information, such as provider addresses, group data, summary calendar and year-to-date (YTD) claims submittal and payment data		
		e.) Interfaces		
		The Provider Data Maintenance function must accommodate an external interface with:		
		1.) The Department; and		
		2.) Other governmental agencies to receive licensure information.		
	152	**4.) Reference**		
		The reference function maintains pricing files for procedures and drugs including Mental/Behavioral Health Drugs and maintains other general reference information such as diagnoses and reimbursement parameters/modifiers. The reference function provides a consolidated source of reference information which is accessed by the MIS during performance of other functions, including claims and encounter processing, TPL processing and utilization/quality reporting functions.		
		a.) Inputs		
		The inputs to the Reference Data Maintenance function are:		
		NDC codes		
		CMS - HCPCS updates		
		ICD-9-CM or 10 and DSM III diagnosis and procedure updates		
		ADA (dental) codes		
		b.) Processing Requirements		
		The Reference Processing function must include the following capabilities:		
		1.) Maintain current and historical reference data, assuring that updates do not overlay or otherwise make historical information inaccessible.		
		2.) Accept on-line and batch updates, additions, and deletions to all reference files, with the capability to make changes to individual records or mass changes to groups or classes of records (for example, across provider type and specialty).		
		3.) Maintain a Procedure data set which is keyed to the five-character HCPCS code for medical-surgical and other professional services, ADA dental codes; a two-character field for HCPCS pricing modifiers; and the Department's specific codes for other medical services; in addition, the procedure data set will contain, at a minimum, the following elements for each procedure:		
		Thirty-six (36) months of date-specific pricing segments, including a pricing action code, effective beginning and end dates, and allowed amounts for each segment.		
		Thirty-six (36) months of status code segments with effective beginning and end dates for each segment.		
		Multiple modifiers and the percentage of the allowed price applicable to each modifier.		
		Indication of TPL actions, such as Cost Avoidance, Benefit Recovery or Pay, by procedure code.		
		Other information such as accident-related indicators for possible TPL, federal cost-sharing indicators, Medicare coverage and allowed amounts.		
	153	4.) Maintain a diagnosis data set utilizing the three (3), four (4), and five (5) character ICD-9-CM and ICD-10 and DSM III coding system, which supports relationship editing between diagnosis code and claim information including but not limited to:		
		Valid age		
		Valid sex		
		Family planning indicator		
		Prior authorization requirements		
		EPSDT indicator		
		Trauma diagnosis and accident cause codes		
		Description of the diagnosis		
		Permitted primary and secondary diagnosis code usage		
		5.) Maintain descriptions of diagnoses.		
		6.) Maintain flexibility in the diagnosis file to accommodate expanded diagnosis codes with the implementation of ICD-10.		
		7.) Maintain a drug data set of the eleven (11) digit National Drug Code (NDC), including package size, which can accommodate updates from a drug pricing service and the CMS Drug Rebate file updates; the Drug data set must contain, at a minimum:		
		Unlimited date-specific pricing segments that include all prices and pricing action codes needed to adjudicate drug claims.		
		Indicator for multiple dispensing fees		
		Indicator for drug rebate including name of manufacturer and labeler codes.		

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		Description and purpose of the drug code.		
		Identification of the therapeutic class.		
		Identification of discontinued NDCs and the termination date.		
		Identification of CMS Rebate program status.		
		Identification of strength, units, and quantity on which price is based.		
		Indication of DESI status (designated as less than effective), and IRS status (identical, related or similar to DESI drugs).		
		8.) Maintain a Revenue Center Code data set for use in processing claims for hospital inpatient/outpatient services, home health, hospice, and such.		
		9.) Maintain flexibility to accommodate multiple reimbursement methodologies, including but not limited to fee-for-service, capitation and carve-outs from Capitated or other "all inclusive" rate systems, and DRG reimbursement for inpatient hospital care, etc.		
		10.) Maintain pricing files based on:		
		Fee schedule		
		Per DIEM rates		
		Capitated rates		
		Federal maximum allowable cost (FMAC), estimated acquisition (EAC) for drugs		
		Percentage of charge allowance		
		Contracted amounts for certain services		
		Fee schedule that would pay at variable percentages.		
		(MAC) Maximum allowable cost pricing structure		
		c.) On-line Inquiry and Update Screens		
		Maintain on-line access to all Reference files with inquiry by the appropriate service code, depending on the file or table being accessed.		
		Maintain on-line inquiry to procedure and diagnosis files by name or description including support for phonetic and partial name search.		
		Provide inquiry screens that display:		
		All relevant pricing data and restrictive limitations for claims processing including historical information, and		
		All pertinent data for claims processing and report generation.		
		d.) Interfaces		
		The Reference Data Maintenance function must interface with:		
		1.) ADA (dental) codes		
		2.) CMS-HCPCS updates;		
		3.) ICD-9, ICD-10, DSM, or other diagnosis/surgery code updating service; and		
		4.) NDC Codes.		
	154	**5.) Financial**		
		The financial function encompasses claim payment processing, adjustment processing, accounts receivable processing, and all other financial transaction processing. This function ensures that all funds are appropriately disbursed for claim payments and all post-payment transactions are applied accurately. The financial processing function is the last step in claims processing and produces remittance advice statements/explanation of benefits and financial reports.		
		a.) Inputs		
		The Financial Processing function must accept the following inputs:		
		1.) Adjusted Claims and Claim adjustments from the claims processing system;		
		2.) On-line entered, non-claim-specific financial transactions, such as recoupments, mass adjustments, cash transactions, etc;		
		3.) Retroactive changes to Member financial liability and TPL retroactive changes from the Member data maintenance function;		
		4.) Provider, Member, and reference data from the MIS.		
		b.) Processing Requirements		
		The MIS must perform three types of financial processing: 1) payment processing; 2) adjustment processing; 3) other financial processing. Required system capabilities are classified under one of these headings in this subsection.		
		1.) Payment Processing		
		Claims that have passed all edit, audit, and pricing processing, or which have been denied, must be processed for payment by the Contractor. Payment processing must include the capability to:		
		a.) Maintain a consolidated accounts receivable function and deduct/add appropriate amounts and/or percentages from processed payments.		
		b.) Generate or reproduce provider remittance advice (RA's), covering activity during a specified period of time, in electronic and/or hard copy media, to include the following information:		
		An itemization of submitted claims that were paid, denied, or adjusted, and any financial transactions that were processed for that provider, including subtotals and totals;		
		Indication that a claim has been rejected due to TPL coverage on file for the recipient with available relevant TPL data on the RA;		
		Explanatory messages relating to the claim payment cutback, denial, or suspension;		
		List of all relevant error messages per claim header and claim detail which would cause a claim to be denied or suspended; and		
		Adjusted claim information showing amount and reason.		
		c.) Update individual provider payment data and 1099 data on the Provider database.		
		2.) Adjustment Processing		
		The MIS adjustment processing function must have the capabilities to:		
		a) Maintain complete audit trails of adjustment processing activities on the claims history files.		
		b) Update provider payment history and recipient claims history with all appropriate financial information and reflect adjustments in subsequent reporting, including claim-specific and non claim-specific recoveries.		

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		c) Maintain the original claim and the results of all adjustment transactions in claims history; link all claims and subsequent adjustments by control number, providing for identification of previous adjustment and original claim number.		
		d) Reverse the amount previously paid/recovered and then processes the adjustment so that the adjustment can be easily identified.		
		e) Re-edit, re-price, and re-audit each adjustment including checking for duplication against other regular and adjustment claims, in history and in process.		
		f) Maintain adjustment information which indicates who initiated the adjustment, the reason for the adjustment, and the disposition of the claim (additional payment, recovery, history only, etc.) for use in reporting the adjustment.		
		g) Maintain an adjustment function to re-price claims, within the same adjudication cycle, for retroactive pricing changes, Member liability changes, Member or provider eligibility changes, and other changes necessitating reprocessing of multiple claims.		
		h) Maintain a retroactive rate adjustment capability which will automatically identify all Claims affected by the adjustment, create adjustment records for them, reprocess them, and maintain a link between the original and adjusted Claim.		
		3.) Other Financial Processing		
		Financial transactions such as stop payments, voids, reissues, manual checks, cash receipts, repayments, cost settlements, overpayment adjustments, recoupments, and financial transactions processed outside the MIS are to be processed as part of the Financial Processing function. To process these transactions, the MIS must have the capability to:		
		a.) Maintain the following information:		
		Program identification (for example, TPL recovery, rate adjustment);		
		Transaction source (for example, system generated, refund, Department generated);		
		Provider number/entity name and identification number;		
		Payment/recoupment detail (for example, dates, amounts, cash or recoupment);		
		Account balance;		
		Reason indicator for the transaction (for example, returned dollars from provider for TPL, unidentified returned dollars, patient financial liability adjustment);		
		Comment section;		
		Type of collection (for example, recoupment, cash receipt);		
		Program to be affected;		
		Adjustment indicator; and		
		Internal control number (ICN) (if applicable).		
		b.) Accept manual or automated updates including payments, changes, deletions, suspensions, and write-offs, of financial transactions and incorporate them as MIS financial transactions for purposes of updating claims history, Provider/Member history, current month financial reporting, accounts receivable, and other appropriate files and reports.		
		c.) Maintain sufficient controls to track each financial transaction, balance each batch, and maintain appropriate audit trails on the claims history and consolidated accounts receivable system, including a mechanism for adding user narrative.		
		d.) Maintain on-line inquiry to current and historical financial information with access by Provider ID or entity identification, at a minimum to include:		
		Current amount payable/due		
		Total amount of claims adjudication for the period		
		Aging of receivable information, according to user defined aging parameters		
		Receivable account balance and established date		
		Percentages and/or dollar amounts to be deducted from future payments		
		Type and amounts of collections made and dates		
		Both non-claim-specific, and		
		Data to meet the Department's reporting.		
		e.) Maintain a recoupment process that sets up Provider accounts receivable that can be either automatically recouped from claims payments or satisfied by repayments from the provider or both.		
		f.) Maintain a methodology to apply monies received toward the established recoupment to the accounts receivable file, including the remittance advice date, number, and amount, program, and transfer that data to an on-line provider paid claims summary.		
		g.) Identify a type, reason, and disposition on recoupments, payouts, and other financial transactions.		
		h.) Provide a method to link full or partial refunds to the specific Claim affected, according to guidelines established by the Department.		
		i.) Generate provider 1099 information annually, which indicate the total paid claims plus or minus any appropriate adjustments and financial transactions.		
		j.) Maintain a process to adjust providers' 1099 earnings with payout or recoupment or transaction amounts through the accounts receivable transactions.		
		k.) Maintain a process to accommodate the issuance and tracking of non-provider-related payments through the MIS (for example, a refund or an insurance company overpayment) and adjust expenditure reporting appropriately.		
		l.) Track all financial transactions, by program and source, to include TPL recoveries, Fraud, Waste and Abuse recoveries, provider payments, drug rebates, and so forth.		
		m.) Determine the correct federal fiscal year within claim adjustments and other financial transactions are to be reported.		
		4.) Reports		
		Reports from the financial processing function are described in Attachment XI and section 10.6.		
	157	**6.) Utilization/Quality Improvement**		
		The utilization/quality improvement function combines data from other external systems, such as Geo Network to produce reports for analysis which focus on the review and assessment of access and availability of services and quality of care given, detection of over and under utilization, and the development of user-defined reporting criteria and standards. This system profiles utilization of Providers and Members and compares them against experience and norms for comparable individuals.		
		This system supports tracking utilization control function(s) and monitoring activities for inpatient admissions, emergency room use, and out-of-area services.		
		It completes Provider profiles, occurrence reporting, monitoring and evaluation studies, and Member/Provider satisfaction survey compilations. The subsystem may integrate the Contractor's manual and automated processes or incorporate other software reporting and/or analysis programs.		

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		This system also supports and maintains information from Member surveys, Provider and Member Grievances, Appeal processes.		
		a.) Inputs		
		The Utilization/Quality Improvement system must accept the following inputs:		
		1.) Adjudicated Claims from the claims processing subsystem;		
		2.) Provider data from the provider subsystem;		
		3.) Member data from the Member subsystem.		
		b.) Processing Requirements		
		The Utilization/Quality Improvement function must include the following capabilities:		
		Maintain Provider credentialing and recredentialing activities.		
		1) Maintain Contractor's processes to monitor and identify deviations in patterns of treatment from established standards or norms. Provide feedback information for monitoring progress toward goals, identifying optimal practices, and promoting continuous improvement.		
		2) Maintain development of cost and utilization data by Provider and services.		
		3) Provide aggregate performance and outcome measures using standardized quality indicators similar to Medicaid HEDIS as specified by the Department.		
		4) Support focused quality of care studies.		
		5) Support the management of referral/utilization control processes and procedures.		
		6) Monitor PCP referral patterns.		
		7) Support functions of reviewing access, use and coordination of services (i.e. actions of peer review and alert/flag for review and/or follow-up; laboratory, x-ray and other ancillary service utilization per visit).		
		8) Store and report Member satisfaction data through use of Member surveys, Grievance/Appeals processes, etc.		
		9) Provide Fraud, Waste and Abuse detection, monitoring and reporting.		
		c.) Reports		
		Utilization/quality improvement reports are listed in Attachments III and XII.		
	158	**7.) Claims Control and Entry**		
		The Claims Control function ensures that all claims are captured at the earliest possible time and in an accurate manner. This function monitors the movement and distribution of Claim once they are received by the Contractor to ensure an accurate trail from receipt of Claims through data entry, to final disposition.		
		After Claims have been prepared for processing during Claims receipt and control, they are entered into the MIS for pricing and edit/audit processing. The Claims Entry function ensures the accuracy, reasonableness, and integrity of MIS entered data for further processing.		
		The Claims Entry function of the MIS may accept Claims, adjustments and other transactions via hard copy and batch electronic media to include tape, diskette, and transmission over telecommunication lines.		
		a.) Inputs		
		Inputs to the Claims control and entry function consist of the:		
		CMS-1500;		
		UB-92/UB-04;		
		ADA (Dental) Claim Form; and		
		NCPDP 5.1		
		b.) Processing Requirements		
		The processing capabilities that must be present in the MIS to support the Claims control and entry function are:		
		1.) Identify, upon receipt, each Claim, adjustment, and financial transaction with a unique control number that includes date of receipt, batch number, and sequence of document within the batch.		
		2.) Monitor and track all Claims, adjustments, and financial transactions from receipt to final disposition.		
		3.) Maintain an image of all Claims, attachments, adjustment requests, and other documents for a one-year period.		
		4.) Edit to prevent duplicate entry of Claim forms.		
		5.) An audit trail for each Claim record that shows each stage of processing, the date the Claim was entered in each stage, and any error codes posted to the Claim at each step in processing.		
	159	**8.) Edit/Audit Processing**		
		The Edit/Audit Processing function ensures that Claims are processed in accordance with Contractor policy. This processing includes application of non-history-related edits and history-related audits to the Claim. Claims are screened against Member and Provider eligibility information; pended and paid/denied claims history; and procedure, drug, diagnosis, and edit/audit information. Those Claims that exceed Program limitations or do not satisfy Program or processing requirements, suspend or deny with system assigned error messages related to the Claim.		
		a.) Inputs		
		The inputs to the Edit/Audit Processing function are:		
		1.) The Claims that have been entered into the claims processing system from the claims entry function;		
		2.) Member, Provider, reference data required to perform the edits and audits.		
		b.) Processing Requirements		
		Basic editing necessary to pass the Claims onto subsequent processing requires that the MIS have the capabilities to:		
		1) Edit each data element on the Claim record for required presence, format, consistency, reasonableness, and/or allowable values.		
		2) Edit to assure that the services for which payment is requested are covered.		
		3) Edit to assure that all required attachments are present.		
		4) Maintain a function to process all Claims against an edit/audit criteria table and an error disposition file (maintained in the Reference Data Maintenance function) to provide flexibility in edit and audit processing.		
		5) Edit for prior authorization requirements and to assure that a prior authorization number is present on the Claim and matches to an active Prior Authorization on the MIS.		

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		6) Edit Prior-Authorized claims and cut back billed units or dollars, as appropriate, to remaining authorized units or dollars, including Claims and adjustments processed within the same cycle.		
		7) Maintain edit disposition to deny Claims for services that require Prior Authorization if no Prior Authorization is identified or active.		
		8) Update the Prior Authorization record to reflect the services paid on the Claim and the number of services still remaining to be used.		
		9) Perform relationship and consistency edits on data within a single Claim for all Claims.		
		10) Perform automated audit processing (e.g., duplicate, conflict, etc.) using history Claims, suspended Claims, and same cycle Claims.		
		11) Edit for potential duplicate claims by taking into account group and rendering Provider, multiple Provider locations, and across Provider and Claim types.		
		12) Identify exact duplicate claims.		
		13) Perform automated audits using duplicate and suspect-duplicate criteria to validate against history and same cycle claims.		
		14) Maintain audit trail of all error code occurrences linked to a specific Claim line or service, if appropriate.		
		15) Edit and suspend each line on a multi-line Claim independently.		
		16) Edit each Claim record completely during an edit or audit cycle, when appropriate, rather than ceasing the edit process when an edit failure is encountered.		
		17) Identify and track all edits and audits posted to the claim from suspense through adjudication.		
		18) Update Claim history files with both paid and denied Claims from the previous audit run.		
		19) Maintain a record of services needed for audit processing where the audit criteria covers a period longer than thirty-six (36) months (such as once-in-a-lifetime procedures).		
		20) Edit fields in Attachment for validity (numerical field, appropriate dates, values, etc.).		
	161	**9.) Claims Pricing**		
		The Claims Pricing function calculates the payment amount for each service according to the rules and limitations applicable to each Claim type, category of service, type of provider, and provider reimbursement code. This process takes into consideration the Contractor allowed amount, TPL payments, Medicare payments, Member age, prior authorized amounts, and any co-payment requirements. Prices are maintained on the Reference files (e.g., by service, procedure, supply, drug, etc.) or provider-specific rate files and are date-specific.		
		The Contractor MIS must process and pay Medicare Crossover Claims and adjustments.		
		a.) Inputs		
		The inputs into the Claims Pricing function are the Claims that have been passed from the edit/audit process.		
		The Reference and Provider files containing pricing information are also inputs to this function.		
		b.) Processing Requirements		
		The Claims Pricing function of the MIS must have the capabilities to:		
		1) Calculate payment amounts according to the fee schedules, per diems, rates, formulas, and rules established by the Contractor.		
		2) Maintain access to pricing and reimbursement methodologies to appropriately price claims at the Contractor's allowable amount.		
		3) Maintain flexibility to accommodate future changes and expanded implementation of co pays.		
		4) Deduct Member liability amounts from payment amounts as defined by the Department.		
		5) Deduct TPL amounts from payments amounts.		
		6) Provide adjustment processing capabilities.		
	161	**10.) Claims Operations Management**		
		The Claims Operations Management function provides the overall support and reporting for all of the Claims processing functions.		
		a.) Inputs		
		The inputs to the Claims Operations Management function must include all the claim records from each processing cycle and other inputs described for the Claims Control and Entry function.		
		b.) Processing Requirements		
		The primary processes of Claims Operations Management are to maintain sufficient on-line claims information, provide on-line access to this information, and produce claims processing reports. The claims operations management function of the MIS must:		
		1.) Maintain Claim history at the level of service line detail.		
		2.) Maintain twenty-four (24) months of adjudicated (paid and denied) claims history. Claims history must include at a minimum:		
		All submitted diagnosis codes (including service line detail, if applicable);		
		Line item procedure codes, including modifiers;		
		Member ID and medical coverage group identifier;		
		Billing, performing, referring, and attending provider Ids and corresponding provider types;		
		All error codes associated with service line detail, if applicable;		
		Billed, allowed, and paid amounts;		
		TPL and Member liability amounts, if any;		
		Prior Authorization number;		
		Procedure, drug, or other service codes;		
		Place of service;		
		Date of service, date of entry, date of adjudication, date of payment, date of adjustment, if applicable.		
		3.) Maintain non-claim-specific financial transactions as a logical component of Claims history.		
		4.) Provide access to the adjudicated and Claims in process, showing service line detail and the edit/audits applied to the Claim.		
		5.) Maintain accurate inventory control status on all Claims.		
		c.) Reports		
		The following reports must be available from the Claims processing function thirty days after the end of each month:		
		1) Number of Claims received, paid, denied, and suspended for the previous month by provider type with a reason for the denied or suspended claim.		
		2) Number and type of services that are prior-authorized (PA) for the previous month (approved and denied).		

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		3) Amount paid to providers for the previous month by provider type.		
		4) Number of Claims by provider type for the previous month, which exceed processing timelines standards defined by the Department.		
		Additional detail found in Attachment XI.		
	162	**11.) Encounter Record**		
		At a minimum, the Contractor will be required to electronically provide encounter Record to the Department on a monthly basis. Encounter Record must follow the format, data elements and method of transmission specified by the Department.		
		Encounter data will be utilized by the Department for the following purposes: 1) to evaluate access to health care, availability of services, quality of care and cost effectiveness of services, 2) to evaluate contractual performance, 3) to validate required reporting of utilization of services, 4) to develop and evaluate proposed or existing capitation rates, and 5) to meet CMS Medicaid reporting requirements.		
		a.) Submissions		
		The Contractor is required to electronically submit Encounter Record to the Department by the 15th of each month. The submission is to include all adjudicated (paid and denied) Claims, corrected claims and adjusted claims processed by the Contractor for the previous month. Monthly Encounter Record transmissions that exceed a 5% threshold error rate (total claims/documents in error equal to or exceed 5% of claims/documents records submitted) will be returned to the Contractor in their entirety for correction and resubmission by the Contractor. Encounter data transmissions with a threshold error rate not exceeding 5% will be accepted and processed by the Department. Only those encounters that hit threshold edits will be returned to the contractor for correction and resubmission. Denied claims submitted for encounter processing will not be held to normal edit requirements and rejections of denied claims will not count towards the minimum 5% rejection.		
		Encounter Record must be submitted in the format defined by the Department as follows:		
		1.) Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0 by January 1, 2012.	Version differences	Version differences
		2.) Conversion from ICD-9 to ICD-10 for medical diagnosis and inpatient procedure coding by October 1, 2013.	Version differences	Version differences
		The Contractor is required to use procedure codes, diagnosis codes and other codes used for reporting Encounter data in accordance with guidelines defined by the Department. The Contractor must also use appropriate provider numbers as directed by the Department for Encounter data. The Encounter Record will be received and processed by Fiscal Agent and will be stored in the existing MIS.		
		b.) Encounter Corrections		
		Encounter corrections (encounter returned to the Contractor for correction, i.e., incorrect procedure code, blank value for diagnosis codes) will be transmitted to the Contractor electronically for correction and resubmission. Penalties will be assessed against the Contractor for each Encounter record, which is not resubmitted within ninety (90) days of the date the record is returned. The Contractor shall have the opportunity to dispute appropriateness of assessment of penalties prior to them occurring to attest to ongoing efforts regarding data acceptance.		
		c.) Annual Validity Study		
		The Department will conduct an annual validity study to determine the completeness, accuracy and timeliness of the Encounter Record provided by the Contractor.		
		Completeness will be determined by assessing whether the Encounter record transmitted includes each service that was provided. Accuracy will be determined by evaluating whether or not the values in each field of the Encounter record accurately represent the service that was provided. Timeliness will be determined by assuring that the Encounter record was transmitted to the Department the month after adjudication.		
		The Department will randomly select an adequate sample which will include hospital claims, provider claims, drug claims and other claims (any claims except in-patient hospital, provider and drug), to be designated as the Encounter Processing Assessment Sample (EPAS). The Contractor will be responsible to provide to the Department the following information as it relates to each Claim in order to substantiate that the Contractor and the Department processed the claim correctly:		
		A copy of the claim, either paper or a generated hard copy for electronic claims;		
		Data from the paid claim's file;		
		Member eligibility/enrollment data;		
		Provider eligibility data;		
		Reference data (i.e., diagnosis code, procedure rates, etc.) pertaining to the Claim;		
		Edit and audit procedures for the Claim;		
		A copy of the remittance advice statement/explanation of benefits;		
		A copy of the Encounter Record transmitted to the Department; and		
		A listing of Covered Services.		
		The Department will review each Claim from the EPAS to determine if complete, accurate and timely Encounter Record was provided to the Department. Results of the review will be provided to the Contractor. The Contractor will be required to provide a corrective action plan to the Department within sixty (60) Days if deficiencies are found.		
Attachment IV	168	**Network Providers**		
		Contractor shall transmit the following data elements to the Department to identify Providers in Contractor's Network.		
		Field Field Length		
		Filler 20		
		Contractor region 1		
		Contractor name 45		
		Contractor provider number 8		
		Network provider's provider number 8		
		(same number used by Medicaid)		
		Provider name:		
		Last 20		
		first 19		

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		Middle initial 1		
		Title 5		
		Address of Practice (physical address) 10 occurrences:		
		Line 1 28		
		line 2 28		
		line 3 28		
		City 18		
		State 2		
		ZIP 9		
		Mailing address:		
		Line 1 28		
		Line 2 28		
		Line 3 28		
		City 18		
		State 2		
		ZIP 9		
		telephone number: 10		
		county code: 3		
		specialty code 5 occurrences: 2		
		effective begin date: 8		
		end date: 8		
		status code: 1		
		SSN or FEIN, as appropriate: 9		
		Medicare provider numbers		
		5 occurrences: 7		
		Type of practice code		
		(IRS requirement): 1		
		Type of ownership code		
		(IRS requirement): 1		
		Provider type code: 2		
		Category of service code: 2		
		CLIA certification number: 10		
		District code (ADD district): 2		
		HMO District code		
		(Managed Care Region): 2		
		Disclosure of Ownership Data		
		status code: 2		
		name: 20		
		last		
		first 12		
		middle initial 1		
		owner SSN or FEIN 9		
		owner begin date 8		
		owner end date 8		

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		Primary care provider quota: 4		
		Primary care provider		
		number of recipients assigned: 4		
		DEA number: 9		
		National Practitioner		
		Database Indicator: 1		
		***Provider Sex: 1**		
		***Provider Date of Birth: 8**		
		***Provider Race: 1**		
		Provider UPIN: 6		
		National Provider Identifier: 8		
		Filler: 20		
		*Information concerning provider sex, age and race is obtained by the Department solely for purposes of monitoring the level of provider diversity in the Contractor's Network. Such information shall not be used by the Contractor in making enrollment and credentialing decisions, and the Contractor shall indemnify the Department for any liability therefore, in accordance with the terms and conditions of the Department's Contract with Contractor.		
Attachment VII	186	**Program Integrity**		
		ORGANIZATION:		
		The Contractor's PIU (PIU) shall be organized so that:		
		a.) Required Fraud, **Waste and** Abuse activities shall be conducted by staff that shall have sufficient authority to direct PIU activities;	Bold not included	Bold not included
		b,) The unit shall be able to establish, control, evaluate and revise Fraud, **Waste and** Abuse detection, deterrent and prevention procedures to ensure their compliance with Federal and State requirements;	Bold not included	Bold not included
		c.) Adequate staff shall be assigned to the PIU to enable them to conduct the functions specified in this Attachment on a continuous and on-going basis; and		
		d.) The unit shall be able to prioritize work coming into the unit to ensure that cases with the greatest potential program impact are given the highest priority. Allegations or cases having the greatest program impact include cases involving:		
		1.) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries;		
		2.) High dollar amount of potential overpayment; or		
		3.) Likelihood for an increase in the amount of ~~F~~raud or A~~b~~use or enlargement of a pattern.		
		FUNCTION:		
		The Contractor shall establish a PIU to identify and refer to the OIG any suspected Fraud or Abuse concerning the health care services of Members.		
		The Contractor's PIU shall be responsible for:		
		a.) Preventing Fraud, **Waste and** Abuse by identifying vulnerabilities in the Contractor's program and taking appropriate **action including but not limited to the following**:	Bold not included	Bold not included
		1.) Recoupment of overpayments;	Not included	Not included
		2.) Changes to policy;	Not included	Not included
		3.) Dispute resolution meetings; and	Not included	Not included
		4.) Appeals.	Not included	Not included
		b.) Proactively detecting incidents of Fraud, **Waste and** Abuse that exist within the Contractor's program **through the use of algorithm, investigations and record reviews;**	Bold not included	Bold not included
		c.) Determining the factual basis of allegations concerning fraud or abuse made by Members, Providers and other sources;		
		d.) Initiating appropriate administrative actions to deny or to suspend payments that should not be made to Providers where there is reliable evidence of Fraud or Abuse;		
		e.) Referring Fraud, **Waste and** Abuse cases to the OIG (carbon copy to the Department's PIU) for investigation and possible referral for civil and criminal prosecution and administrative sanctions;	Bold not included	Bold not included
		f.) Initiating and maintaining network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside		
		groups; and		
		g.)Making recommendations to enhance the Parties' ability to prevent, detect and deter Fraud, **Waste or** Abuse.	Bold not included	Bold not included

Contract Reference	Page #	SFY 2011 Contract Language	SFY 2010	SFY 2009
		The Contractor's PIU shall:		
		a.) Conduct continuous and on-going reviews of all MIS data including Member and Provider Grievances and appeals for the purpose of identifying potentially fraudulent acts;		
		b.) Conduct regularly scheduled post-payment audits of provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Contractor, the Department, and OIG, as appropriate;		
		(c) Maintain cases under investigation for possible Fraud, **Waste** or Abuse activities and provide these lists **and entire case files** to the Department, and OIG upon demand;	Bold not included	Bold not included
		d.) Designate a contact person to work with investigators and attorneys from the Department, and OIG		
		e.) To ensure the integrity of PIU referrals to the OIG, referrals by the unit shall not be subject to the approval of partnership management officials;		
		f.) Contractor shall comply with the expectations of 42 CFR 455.20 (a) by employing a method of verifying with recipients whether the services billed by provider were received; and	Not included	Not included
		g.) Contractor shall have a method for attempting to collect administratively on member overpayments that were declined prosecution known as Medicaid Program Violations (MPV) letters for member and recover payments from provider.	Not included	Not included
		PATIENT ABUSE:		
		Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law and carbon copy the Department for Medicaid Services, OIG Division of Fraud, Waste and Abuse.		
		COMPLAINT SYSTEM:		
		The Contractor's PIU shall operate a system to receive, investigate and track the status of Fraud, **Waste** and Abuse complaints **received** from members, providers and all other sources which may be made against the Contractor, providers or members. **The system shall contain the following**:		
		a.) Upon receipt of a complaint or other indication of potential fraud or abuse, the Contractor's PIU shall conduct a limited preliminary inquiry to determine the validity of the complaint.		
		b.) The PI should review background information and MIS data; however, the preliminary inquiry should not include interviews with the subject concerning the alleged instance of Fraud or Abuse.		
		c) Should the preliminary inquiry result in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PI should not refer the case to OIG; however, the PI should take whatever remedial actions may be necessary.		
		d.) Should the preliminary inquiry result in a reasonable belief that Fraud or Abuse has occurred, the PI should refer the case (using the standardized complaint form,) and all supporting documentation to the OIG, with a copy to DMS.		
		e.) OIG will review the referral and attached documentation and make a determination as to whether OIG will investigate the case or return it to the PI for them to conduct a preliminary investigation.		
		f.) OIG will notify the PI in a timely manner as to whether the OIG will investigate or whether the PI should conduct a preliminary investigation.		
		g.) If, in the process of conducting a preliminary investigation, the PI suspects a violation of either criminal Medicaid fraud statutes or the Federal False Claims Act, the PI shall immediately notify the OIG of their findings and proceed only in accordance with instructions received from the OIG.		
		h.) If OIG determines that it will keep a case referred by the PI, the OIG will conduct an investigation, gather evidence, write a report and forward information to DMS and the PI for appropriate actions.		
		i.) If OIG opens an investigation based on a complaint received from a source other than the Contractor, OIG will, upon completion of the investigation, provide a copy of the investigative report to DMS and the -PI for appropriate actions.		
		j.) If OIG investigation results in a referral to the Attorney General's Medicaid Fraud Control Unit and/or the U.S. Attorney, the OIG will notify DMS and the PI of the referral. DMS and the -PI should only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral.		
		k.) Upon completion of the PI's preliminary investigation, the PI should provide OIG a copy of their investigative report, which should contain the following elements:	Subtle differences in reports	Subtle differences in reports
		1.) Name and address of subject,		
		2.) Medicaid identification number,		
		3.) Address of subject,		
		4.) Source of complaint,		
		5.) State the complaint/allegation,		
		6.) Date assigned to the investigator,		
		7.) Name of investigator,		
		8.) Date of completion,		
		9.) Methodology used **during** investigation,		
		10.) Facts discovered by the investigation **as well as the full case report and supporting documentation,**		
		11.) Attach **all** exhibits or supporting documentation,		
		12.) Include recommendations as considered necessary, for administrative action or policy revision,		
		13.) Identify overpayment, if any, and include recommendation concerning collection,		
		l.) The **Contractor's PIU** provide OIG and DMS a quarterly **member and provider** status report of all cases including actions taken to implement recommendations and collection of overpayments,	Bold not included	Bold not included
		m.) The **Contractor's PIU** shall maintain access to a follow-up system, which can report the status of a particular complaint or grievance process or the status of a specific recoupment;		
		n.) The **Contractor's PIU** shall assure a Grievance **and** appeal process for Members and Providers.	"Or" changed to "and"	"Or" changed to "and"
		REPORTING:		
		If any internal component of the Contractor discovers or is made aware of an incident of possible Member or Provider Fraud, **Waste** or Abuse, the incident shall be immediately reported to the PIU Coordinator.	Bold not included	Bold not included

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		The Contractor's PIU shall report all cases of suspected ~~F~~raud, ~~A~~buse or inappropriate practices by Subcontractors, Members or employees to the OIG.		
		The Contractor is required to report the following data elements to the Department and the OIG on a quarterly basis, in an excel format:		
		PHP Case number,		
		OIG Case Number,		
		Business/**Member** name,	"Member" previously "recipient"	"Member" previously "recipient"
		Provider/Member number,		
		Date complaint received by Contractor,		
		Source of complaint,	Not included	Not included
		Date opened,		
		Summary of Complaint,		
		Is complaint substantiated or not substantiated (Y or N answer only under this column),		
		PHP action Taken **(only provide the most current update);**	Minor change	Minor change
		Amount of overpayment (if any),		
		Administrative actions taken to resolve findings of completed cases including the following information:		
		The overpayment required to be repaid and overpayment collected to date;		
		Describe sanctions/withholds applied to Providers/**Members**, if any;	"Member" previously "recipient"	"Member" previously "recipient"
		Provider/**Members** appeal regarding overpayment or requested sanctions. If so, list the date an appeal was requested, date the hearing was held, the date of the final decision, and to the extent they have occurred; and	"Member" previously "recipient"	"Member" previously "recipient"
		Revision of the Contractor's policies to reduce potential risk from similar situations with a description of the **policy recommendation, implemented of aforementioned revision and date of implementation.**	Previously "nature and purpose of revision"	Previously "nature and purpose of revision"
		AVAILABILITY AND ACCESS TO DATA:		
		The Contractor shall:		
		a.) Gather, produce, keep and maintain records including, but not limited to, ownership disclosure, submissions, applications, evaluations, qualifications, member information,		
		enrollment lists, grievances, Encounter data, **desk reviews, investigations, investigative supporting documentation, finding letters** and subcontracts.	Bold not included	Bold not included
		b.) Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department, and the OIG,		
		c.) Backup, store or be able to recreate reported data upon demand for the Department, and the OIG,		
		d.) Permit reviews, investigations or audits of all books, records or other data, at the discretion of the OIG,] or other authorized ~~f~~ederal or ~~s~~tate agency; and, shall provide access to Contractor records and other data on the same basis and at least to the same extent that the Department would have access to those same records; and,		
		e.) Produce records in electronic format for review and manipulation by the Department, and the OIG.		
		The Contractor's PIU shall have access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract.		
		The Contractor shall cooperate with the OIG, the United States Attorney's Office and other law enforcement agencies in the investigation of fraud or abuse cases.		
		The Contractor shall provide identity and cover documents and information for law enforcement investigators under cover.		
Attachment IX	191	**Passport Capitation Rate Development**		
		See Separate Tab for this attachment		
Attachment X	192	**Minimum Reporting Requirements**		
		See Separate Tab for this attachment		
Attachment XI	219	**V. GRIEVANCES/APPEALS**		
		A. Grievance Activities During the Report Period		
		Summarize the grievances received by the Partnership during the reporting period. Provide the number, type and resolution of grievances during the report period. (Please note: these logs are the "number, type and resolution." Also under the BBA – complaint and grievances are the same.)		
		B. Appeal Activities during the Report Period.		
		Summarize the appeals received by the Health Plan during the reporting period. Provide the number, type and resolution of grievances during the report period.		
		C. Trends or Problem Areas		
		Discuss any trends or problem areas identified in the appeals and grievances, and the Health Plan's efforts to address any trends.		
		VI. BUDGET NEUTRALITY/FISCAL ISSUES		
		A. Budgetary Issues for the Report Period		
		Provide a discussion of budgetary issues including changes in appropriations, adjustments in the upper payment limits, etc.		
		B. Potential/Anticipated Fiscal Problems		
		Include a discussion of anticipated fiscal problems or issues at the Partnership level. Include such topics as payment of claims, financial solvency, etc.		
		VII. UTILIZATION		
		A. Provide utilization data reports listed as indicated on the chart. Report templates are attached.		

Contract Reference	Page #	SFY 2011 Contract Language	SFY 2010	SFY 2009
		1.) Enrollment Summary Report		
		2.) Ambulatory Care by Age Breakdown		
		3.) Emergency Care and Ambulatory Surgery Resulting in Hospital Admission		
		4.) Emergency Care by ICD-9 Diagnosis		
		5.) Home Health		
		6.) Ambulatory Care by Provider Category and Category of Aid		
		7.) Pharmacy Report		
		a.) Top 50 Drugs – Cost, Number of Prescriptions		
		b.) Top Therapeutic Classes based on top 50 Drugs - Cost, Number of Prescriptions		
		c.) Pharmacy Utilization Statistics		
		B. Monitoring Activities Related to Utilization and Access to Care		
		Discuss the Partnership's use of encounter data and utilization reports to monitor utilization of services and access to care.		
		C. Utilization Trends/Patterns Identified During the Report Period		
		Analyze and discuss trends in utilization, and any unusual patterns about which the Partnership will take subsequent action. Also, discuss areas where over- or under- utilization has been influenced appropriately, i.e., pharmacy and ER utilization management.		
		D. Summary of Denials Rendered during the Report Period		
		Analyze and discuss any unusual patters in the denials rendered during the reporting period.		
		VIII. SYSTEMS		
		A. Systems and Data Development Issues		
		Discuss the status of systems and data development and issues. Include information on plan modification and expected outcomes.		
		B. Claims Processing Timeliness/Encounter Data Reporting		
		Provide a discussion of the status on the timeliness of encounter data reporting and the processing of claims, including steps taken by the Partnership to correct problems.		
		IX. OTHER PARTNERSHIP ACTIVITIES		
		A. Organization Changes		
		Identify organizational changes relating to the Partnership.		
		B. Administrative Changes		
		Identify administrative changes relating to the Partnership		
		C. Innovations Solutions		
		Provide information on additional or innovative program solutions within the Partnership.		
		D. Other		
		Provide any information relevant to the operation of the Partnership not otherwise covered herein.		
		Contract		
2.01	8	**CHFS / Agency Responsibilities**		
		1.) Monitor and evaluate Contractor compliance with requirements of the contract and overall program performance		
		2.) Provide the Contractor with appropriate instructions, submission timetables and technical assignment when needed		
		3.) Conduct a timely review of all materials submitted to the DMS by the Contractor as required		
		4.) Provide timely notification to the Contractor of all changes and /or amendments to the Scope of Work and / or the 1115 waiver terms and conditions, etc.		
3.09	10	**Expenses**		
		The contractor shall only be reimbursed for those expenses that were expressly detailed in the Contract.		
		Invoicing for fee: The contractor's fee shall be documented on an original invoice(s) detailing the work performed and the time frame in which it was performed.		
		Invoicing for travel expenses: If travel expenses are allowed under the contract, either original or certified copies of receipts must be submitted for airline tickets, motel bills, restaurant charges, rental care charges, and other miscellaneous expenses.		
		Invoicing for miscellaneous expenses: Allowable expenses shall be documented on an original invoice or certified copy.		
4.19	15	**Roles and Responsibilities for Proposed and Existing Staff**		
		The roles and responsibilities and the written qualifying criteria for all personnel to be employed under the scope of work for all projects funded under this Contract, including any proposed employees under subcontract to the Second Party, shall be in compliance with state and federal laws governing the distribution of funds and the performance of activities as set forth in this Contract. The Second Party shall maintain and make available, upon written request, documentation of all personnel policies and procedures that govern the recruitment, hiring and performance evaluation for all personnel funded under this Contract. All employees hired by the Second Party or its subcontractors and funded under the terms and conditions of this Contract, shall have position descriptions which set out the required qualifications, skills, and knowledge required to complete the scope of work as set out under this Contract.		
4.22	16	**Travel and Hourly Travel Rate**		
		The Second Party shall not be paid for travel expense unless and except as specifically authorized under the specifications of this Contract. Unless otherwise indicated, travel reimbursement for activities under the terms and conditions of this Contract shall be in accordance with 200 KAR 2:006. No travel time or travel expenses shall be included in the hourly rates of the Second Party's employees, or any subcontractor's employees to the Second Party, under this Contract.		
4.23	16	**Subcontractors**		
		The Contractor shall make no subcontract with any other party for furnishing any of the work or services herein contracted without written consent of the Contract Specialist. This provision shall not require the approval of contracts of employment between the Contractor and personnel assigned for services thereunder. The Contractor shall be solely responsible for performance of the entire Contract whether or not subcontractors are used.		
		All references to the Contractor shall be construed to encompass both the Contractor and any subcontractors of the Contractor.		

Contract Reference	Page #	SFY 2011 Contract Language	SFY 2010	SFY 2009
4.24	16	**Responsibility for Subcontractor Contract Requirements**		
		The Second Party shall have a Contract with any subcontractor that the Second Party contracts with to meet the statement of work, method of payment, and deliverables of this Contract that specifies the responsibilities of the parties and the cost. In addition, the Second Party's Contract with the subcontractor shall specify that all requirements for this Contract are applicable and binding on the subcontractor. Any plan to subcontract any of the provisions of this Contract must be set forth in the Second Party's proposal for the delivery of products or services and included in the body of the contract in the subcontractor's section. The subcontractor must make available to the Second Party and to CHFS, if requested, copies of personnel records and documentation of employees' compliance with the terms and conditions of this Contract.		
		No obligation or right of Second Party under this Contract shall be subcontracted to another, without prior written approval, of CHFS after CHFS has had the opportunity to review all contract documents setting forth the terms and conditions for the subcontract. Second Party, upon the cabinet's request, shall submit the subcontract for approval to: Cabinet for Health and Family Services, Department for Medicaid Services, 275 E. Main St. 6W-C, Frankfort, KY 40621		
4.28	18	**Financial Record Retention**		
		The Second Party agrees to maintain all records pertaining to this contract for a period of not less than three (3) years after all matters pertaining to this contract (e.g., audit, settlement of audit exceptions, disputes) are resolved in accordance with applicable federal and/or state laws, regulations, and policies (except as may otherwise be specified in this contract).		
4.46	25	**Conflict of Interest Laws and Principles**		
		The Second Party certifies that the Second Party is legally entitled to enter into this Contract with the Commonwealth of Kentucky, and by holding and performing this Contract will not be violating either any conflict of interest statute, KRS 45A.330-45A.340, 45A.990, KRS 164.390, or KRS 11A.040 of the Executive Branch Code of Ethics, relating to the employment of former public servants.		
4.47	25	**Campaign Finance**		
		The Second Party certifies that neither he/she not any member of his/her immediate family having an interest of ten percent (10%) or more in any business entity involved in the performance of this Contract, has contributed more than the amount specified in KRS 121.056 (2), to the campaign of the gubernatorial candidate elected at the election last preceding the date of this Contract. The Second Party further swears under the penalty of perjury, as provided by KRS 523.020, that neither he/she nor the company which he/she represents, has knowingly violated any provisions of the campaign finance laws of the Commonwealth, and that the award of a contract to him/her or the company which he/she represents will not violate any provisions of the campaign finance laws of the Commonwealth (Exhibit A).		
4.49	26	**Certification of Lobbying Activities**		
		Second Party shall disclose any lobbying activities in accordance with Section 1352, Title 31, U.S. Code. The Second Party certifies, to the best of his or her knowledge and belief that:		
		No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.		
		If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Members of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form - LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.		
		The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.		
4.54	29	**Confidential Information**		
		The Contractor shall comply with the provisions of the Privacy Act of 1974 and instruct its employees to use the same degree of care as it uses with its own data to keep confidential information concerning client data, the business of the Commonwealth, its financial affairs, its relations with its citizens and its employees, as well as any other information which may be specifically classified as confidential by the Commonwealth in writing to the Contractor. All Federal and State Regulations and Statutes related to confidentiality shall be applicable to the Contractor. The Contractor shall have an appropriate agreement with its employees to that effect, provided however, that the foregoing will not apply to:		
		Information which the Commonwealth has released in writing from being maintained in confidence;		
		Information which at the time of disclosure is in the public domain by having been printed and published and available to the public in libraries or other public places where such data is usually collected; or		
		Information, which, after disclosure, becomes part of the public domain as defined above, through no act of the Contractor.		
		The Contractor shall have an appropriate agreement with its Subcontractors extending these confidentiality requirements to all Subcontractors' employees.		
4.55	29	**Confidentiality, Confidentiality Agreements and Limitations on Information and Data Use**		
		The Second Party agrees that it and any employee or agent acting on its behalf in providing services under this Contract will abide by the state and federal rules and regulations governing access to and use of information and data provided by CHFS or collected by the Second Party and will use such information or data only for those purposes expressly delineated, defined and authorized in this Contract. In the performance of services under this Contract, the Second Party agrees as follows:		
		The Second Party shall cause all personnel who may have access to confidential information provided by CHFS to enter into CHFS approved confidentiality agreements and shall maintain such confidentiality agreements on file. CHFS reserves the right to direct the removal from contract administration, or the termination of access to CHFS provided information, for any individual covered by this Contract who has not signed a confidentiality agreement.		
		Any subcontractor, their agent, and any of their employees who enter into any type of agreement to fulfill the requirements of this contractual agreement with the Second Party, must provide written assurances that they and any of their agents will abide by the terms of confidentiality as set forth in this Contract, as well as any federal or state confidentiality agreements which may govern the terms and conditions in this Contract.		
		Any dissemination of information about projects funded and the scope of work described in the terms and conditions of this Contract, must be fully documented and reviewed by the Cabinet's project manager before any representation, electronic or otherwise, of projects, their funding sources, use of data, or data analyses may be posted to a web page or otherwise published.		

Contract Reference	Page #	SFY 2011 Contract Language	SFY 2010	SFY 2009
		The Second Party shall permit unrestricted access on demand to personnel of the Cabinet, the Office of the Attorney General, the Office of the Auditor of Public Accounts, and any representative of an government funding agency authorized to review records for audit or investigation purposes to its current policies and procedures for ensuring compliance with these confidentiality requirements, the confidentiality agreements with its personnel, and subcontractor confidentiality assurances.		
4.56	30	**HIPAA Confidentiality Compliance**		
		The Second Party agrees to abide by the "HIPAA Privacy Rule," 45 CFR Parts 160 and 164, established under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (42 USC 1320d) to protect the security, confidentiality, and integrity of health information. The Cabinet is a Covered Entity and the Second Party is a Business Associate under the HIPAA Privacy Rule. This rule includes any form of information including paper records, oral communications, audio recordings, electronic displays, etc. In the performance of services under this Agreement, the Second Party agrees to use and disclose Protected Health Information only in accordance with the HIPAA Privacy Rule as follows:		
		To use or disclose Protected Health Information solely for meeting its obligations under this Agreement or as required by applicable law, rule or regulation, or by accrediting or credentialing organizations to who the Cabinet or Second Party is required to disclose such information or as otherwise is permitted under this contract, or the HIPAA Privacy Rule;		
		To implement appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted in this contract;		
		To take reasonable steps to ensure that its employees' actions or omissions do not cause a breach in the terms of the HIPAA Privacy Rule;		
		To make available Protected Health Information to the extent and in the manner required by 45 CFR 164.524, for purposes of accounting of disclosures in accordance with 45 CFR 164.528, and for amendment and incorporation of any amendments in accordance with the requirements of 45 CFR 164.526 of the HIPAA Privacy Rule;		
		To ensure that its agents, including subcontractors, abide by the same restrictions and conditions concerning Protected Health Information contained in this contract and that any subcontract entered into contain this requirement;		
		To report to the Cabinet any use or disclosure of Protected Health Information of which it becomes aware that is not in compliance with the terms of this contract; and		
		To return or destroy copies of all Protected Health Information upon request of the Cabinet or upon terminations of this contract. If such return or destruction is not feasible, the Second Party shall extend the protections of this contract to such information and limit further uses and disclosures to those purposes that make its return or destruction not feasible.		
		Government agencies responsible for HIPAA Privacy Rule compliance and appropriately authorized shall have the right to audit the Second Party's records and practices related to the use and disclosure of Protected Health Information to ensure the Cabinet' compliance with the terms of the HIPAA Privacy Rule. In the event that either party to this contract believes that any provision fails to comply with the then current requirements of the HIPAA Privacy Rule, such party shall notify the other party in writing. For a period of up to thirty days, the parties shall address in good faith such concern and amend the terms of this contract, if necessary to bring it into compliance. If, after such thirty-day period, the contract fails to comply with the HIPAA Privacy Rule, the either party has the right to terminate upon written notice to the other party.		
5.04	33	**False Claims Act**		
		Vendors / subrecipient agrees that it shall promptly refer to an appropriate federal inspector general any credible evidence that a principal, employee, agent, subgrantee, subcontractor, or other person has committed a false claim under the False Claims Act or has committed a criminal or civil violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar misconduct involving those funds.		

Exhibit A
ATTACHMENT X to DMS/UHC Contract

This attachment contains reports required by DMS to meet Federal and State mandates that are described in the contract between the Kentucky Department for Medicaid Services and the Contractor, as well as other report requirements from associated entities such as Center for Medicare and Medicaid Services (CMS), and the Kentucky Office of Insurance (OOI). The parties acknowledge that CMS has requested DMS to provide certain reports concerning Contractor. Contractor agrees to provide DMS with the reports and ad hocs requested by CMS. All required reports shall be submitted accurately and complete to the Contract Compliance Officer in a hard copy binder and electronic format that can be manipulated, such as MS Excel ®. Additionally, the parties agree for Contractor to provide any additional reports requested by DMS upon mutual agreement of the parties. The DSS will not replace or relieve the Contractor from reporting requirements. The parties agree that Attachment XI may be amended outside of the scope of this agreement.

University Health Care, Inc. SFY 2011 Contract
Examples of Minimum Reporting Requirements

Report Name	Description	Frequency	Comments
Quarterly Reports - CMS (template attached) All required reports shall be submitted accurately and complete to the Contract Compliance Officer in a hard copy binder and electronic format that can be manipulated, such as MS Excel ®.			
I. Executive Summary			
Executive Summary	Include a summary of any significant activities, problems or issues, and any program modifications.	Quarterly End of month after end of quarter	See attached format
II. Eligibility/Enrollment			
A. Enrollment Changes During the Quarter	This report includes a narrative that summarizes the information found in VII A1 and also includes a table report on the number of members auto-assigned by the Plan.	Quarterly End of month after end of quarter	
B. PCP Changes During the Quarter	Table format in attached Format Guide	Quarterly End of month after end of quarter	
B1. PCP Assignments Initiated by the Partnership	Table format in attached Format Guide	Quarterly End of month after end of quarter	
B2. PCP Changes by Member	Table format in attached Format Guide, also to be included is a narrative of trends noted from the table.	Quarterly End of month after end of quarter	
B. 3aPCP's with Panel Changes Greater than 50 or 10% - Table	Table format in attached Format Guide	Quarterly End of month after end of quarter	
B. 3b PCP's with Panel Changes Greater than 50 or 10% - Narrative summarizing Table in B.3a.	This is a narrative to accompany the table in requirement B3a above.	Quarterly End of month after end of quarter	
III. Access/Delivery Network			
A. GeoNetworks Reports & Maps (Annually)	The period reported should be of the Current Provider Network and the due date is July 30; Attachment II 6 of the Contract.	Annually July 31st of each year	
B. Access Issues/Problems Identified During the Quarter and/or Remedial Action Taken	See attached Format Guide	Quarterly End of month after end of quarter	
C. Listing of Providers Denied Participation	See attached Format Guide	Quarterly End of month after end of quarter	
D. Subcontracting Issues/Monitoring Efforts	See attached Format Guide	Quarterly End of month after end of quarter	

Exhibit A

University Health Care, Inc. SFY 2011 Contract
Examples of Minimum Reporting Requirements

Report Name	Description	Frequency	Comments
Quarterly Reports - CMS (template attached) All required reports shall be submitted accurately and complete to the Contract Compliance Officer in a hard copy binder and electronic format that can be manipulated, such as MS Excel ®.			
IV. Quality Assurance and Improvement			
A. Internal Quality Assurance Activities During the Quarter			
1. Summary of QI Activities	See attached Format Guide	Quarterly End of month after end of quarter	
2. Monitoring of Indicators, Benchmarks and Outcomes.	See attached Format Guide	Quarterly End of month after end of quarter	
3. Performance Improvement Projects	See attached Format Guide	Quarterly End of month after end of quarter	
4. Utilization of Subpopulations and individuals with special healthcare needs	See attached Format Guide	Quarterly End of month after end of quarter	
5. Partnership Council Activities, including any decisions regarding quality and appropriateness of care	See attached Format Guide	Quarterly End of month after end of quarter	
6. Satisfaction Surveys	See attached Format Guide	Quarterly End of month after end of quarter	
7. Evidence-Based guidelines for practitioners	See attached Format Guide	Quarterly End of month after end of quarter	
B. Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death	See attached Format Guide	Quarterly End of month after end of quarter	
1. Overview of Activities	See attached Format Guide	Quarterly End of month after end of quarter	
2. EPSDT Screening Rates	Table format in attached Format Guide	Quarterly End of month after end of quarter	
C. Credentialing and Recredentialing Activities During the Quarter	See attached Format Guide	Quarterly End of month after end of quarter	
D. Fraud & Abuse Activities During the Quarter	See attached Format Guide	Quarterly End of month after end of quarter	
V. Grievances/Appeals			
A. GrievanceActivities During the Quarter	See attached Format Guide	Quarterly End of month after end of quarter	
B. Appeal Activities During the Quarter	See attached Format Guide	Quarterly End of month after end of quarter	
C. Trends or Problem Areas	See attached Format Guide	Quarterly End of month after end of quarter	

University Health Care, Inc. SFY 2011 Contract
Examples of Minimum Reporting Requirements

Report Name	Description	Frequency	Comments
Quarterly Reports - CMS (template attached) All required reports shall be submitted accurately and complete to the Contract Compliance Officer in a hard copy binder and electronic format that can be manipulated, such as MS Excel ®.			
VI. Budget Neutrality/Fiscal Issues			
A. Budgetary Issues for the Quarter	See attached Format Guide	Quarterly End of month after end of quarter	
B. Potential/Anticipated Fiscal Problems	See attached Format Guide	Quarterly End of month after end of quarter	
VII. Utilization			
A. Utilization Report Tables			
1. UR1. Enrollment Summary Report (1/1-3/31 enrollment submitted 7/30, 1/1-6/30 submitted 10/30, 1/1-9/30 submitted 1/30 and 1/1-12/31 submitted 4/30.)	See attached Format Guide	Quarterly End of month after end of quarter	
2. UR2 – Ambulatory Care – Total Membership by Age Breakdown	See attached Format Guide	Annually April 30th of each year	
3. UR3. Emergency and Ambulatory Care Resulting in Hospital Admission	See attached Format Guide	Annually April 30th of each year	
4. UR4 Emergency Care by ICD-9 Diagnosis	See attached Format Guide	Annually April 30th of each year	
5. UR5. Home Health Utilization	See attached Format Guide	Annually April 30th of each year	
6. UR6 Ambulatory Care (by Provider Type and COA)	See attached Format Guide	Annually April 30th of each year	
7. Pharmacy Report			
7a. Top 50 Drugs - cost, number of prescriptions	See attached Format Guide	Annually April 30th of each year	
7b. Top therapeutic classes based on Top 50 drugs - cost, number of prescriptions	See attached Format Guide	Annually April 30th of each year	
7c. Pharmacy Utilization (# of Members, # of Rx, PMPM cost, Brand vs. Generic)	See attached Format Guide	Annually April 30th of each year	
B. Monitoring Activities Related to Utilization and Access to Care	See attached Format Guide	Quarterly End of month after end of quarter	
C. Utilization Trends/Patterns Identified During the Quarter	See attached Format Guide	Quarterly End of month after end of quarter	
D. Summary of Denials Rendered During the Quarter	See attached Format Guide	Quarterly End of month after end of quarter	
E. UM Call Statistics	See attached Format Guide	Quarterly End of month after end of quarter	

Exhibit A

University Health Care, Inc. SFY 2011 Contract
Examples of Minimum Reporting Requirements

Report Name	Description	Frequency	Comments
Quarterly Reports - CMS (template attached) All required reports shall be submitted accurately and complete to the Contract Compliance Officer in a hard copy binder and electronic format that can be manipulated, such as MS Excel ®.			
VIII. Systems			
A. Systems and Data Development Issues	See attached Format Guide	Quarterly End of month after end of quarter	
B. Claims Processing Timeliness/Encounter Data Processing	See attached Format Guide	Quarterly End of month after end of quarter	
IX. Other Plan Actives			
A. Organizational Changes	See attached Format Guide	Quarterly End of month after end of quarter	
B. Administration Changes	See attached Format Guide	Quarterly End of month after end of quarter	
C. Innovations/P Solutions	See attached Format Guide	Quarterly End of month after end of quarter	
D. Other	See attached Format Guide	Quarterly End of month after end of quarter	
Office of Insurance - Prompt Pay Claims Report			
OOI Claims	The current (as of 11-02) reporting requirement from DOI became effective for the reporting period beginning 7/1/02 and includes claims received within the quarter and due 180 days after the quarter end.	Quarterly 180 Days after end of quarter	
Additional DMS Reports			
COB Savings (disk)	Attachment I and II describes reporting elements.	Monthly 30 days after end of month	
Cost Avoidance Summary Savings (Medicare only)	Attachment I and II describes reporting elements.	Monthly 30 days after end of month	
Cost Avoidance Summary Savings (no Medicare)	Attachment I and II describes reporting elements.	Monthly 30 days after end of month	
Potential Subrogation	Attachment I and II describes reporting elements.	Monthly 30 days after end of month	
Claims Processing Summary	Attachment II describes reporting elements.	Monthly 30 days after end of month	
Claims Processing Summary by Provider Type-Paid	Attachment II describes reporting elements.	Monthly 30 days after end of month	
Claims Processing Summary by Provider Type-Denied	Attachment II describes reporting elements.	Monthly 30 days after end of month	
Claims Processing Summary by Provider Type-Suspended	Attachment II describes reporting elements.	Monthly 30 days after end of month	
Claims Processing Summary by Denial Reason-Denied	Attachment II describes reporting elements.	Monthly 30 days after end of month	
Claims Processing Summary by Denial Reason –Suspended	Attachment II describes reporting elements.	Monthly 30 days after end of month	
Claims Inventory	Attachment II describes reporting elements.	Monthly 30 days after end of month	
Encounter Data	Attachment II describes reporting elements	Monthly 30 days after end of month	

Exhibit A

University Health Care, Inc. SFY 2011 Contract
Examples of Minimum Reporting Requirements

Report Name	Description	Frequency	Comments
Quarterly Reports - CMS (template attached) All required reports shall be submitted accurately and complete to the Contract Compliance Officer in a hard copy binder and electronic format that can be manipulated, such as MS Excel ®.			
1st Newborn Report to DCBS (copy only)		Monthly 30 days after end of month	Section 7.3.1.1
2nd Newborn Report to DMS		Monthly 30 days after end of month	Section 7.3.1.1
Foster Care Report		Monthly 30 days after end of month	Section 8.2.2
Provider Enrollment Report	Attachment II 11.a. describes reporting elements.	Monthly 30 days after end of month	Section 4.1.3
Provider Termination Report	Attachment XI describes reporting elements.	Monthly 30 days after end of month	
Provider Denial Report	Attachment XI describes reporting elements.	Monthly 30 days after end of month	
Passport Outstanding Accounts Receivables Report	Attachment XI describes reporting elements.	Monthly Due on the 15th after month end	
Summary of Member EOMBS	Attachment XI describes reporting elements	Monthly Due on the 15th after month end	
Provider Case Reports	Attachment XI describes reporting elements.	Quarterly by the 30th of the month	
Member Case Reports	Attachment XI describes reporting elements.	Quarterly by the 30th of the month	
Monthly Benefits Payment	Attached XI describes reporting elements.	Quarterly End of month after end of quarter	
Health Screening Questionnare		Quarterly End of month after end of quarter	Section 8.2
Newborn Reconciliation Report		Quarterly End of month after end of quarter	Section 7.3.1
Provider Changes in Network Report		Quarterly End of month after end of quarter	Section 6.8.2.11
Out of Network Utilization by Members		Quarterly End of month after end of quarter	Section 6.8.2.28
EPSDT Reports		Quarterly End of month after end of quarter	Section 8.4
Status of all Subcontractors		Quarterly End of month after end of quarter	Section 1.7.2
Member TPL Resource Information (format)	Attachment II 2b.	Quarterly End of month after end of quarter	
Financial Reports Required by National Accociation of Insurance Commissioners		Quarterly End of month after end of quarter	Section 10.6
Member Grievances and Appeals		Quarterly End of month after end of quarter	Section 7.2.3

Exhibit A

University Health Care, Inc. SFY 2011 Contract
Examples of Minimum Reporting Requirements

Report Name	Description	Frequency	Comments
Quarterly Reports - CMS (template attached) All required reports shall be submitted accurately and complete to the Contract Compliance Officer in a hard copy binder and electronic format that can be manipulated, such as MS Excel ®.			
Reports - from Contract			
Quality Improvement Plan and Evaluation		Annually July 31st of each year	Sectron 5.2 of Contract
Outreach Plan for review & approval by DMS		Annually July 31st of each year	Section 7.1.2
DMS copied on Report to Management of any changes in Member Services function to improve quality of care provided or method of delivery		Annually July 31st of each year	Section 7.1
EPSDT Activities, Utilization & Services and Current 416 form		Annually July 31st of each year	Section 10.4
Audited Financial statements		Annually 175 days following each fiscal year	Section 10.6
Copies of annual statements and reports as required by OOI.		Annually 75 days following each fiscal year	Section 10.6
Absent parent cancelled court order information	Attachment II 2c. (format)	Annually July 31st of each year	
List of the Members participating with the Quality Member Access Advisory Committee.		Annually July 31st of each year	Section 5.7
Performance Improvement Projects (PIP) Proposal		Annually September 1st of each year	Section 5.6
Performance Improvement Project Measurement		Annually September 1st of each year	Section 5.6
EPSDT 416		Annually July 31st of each year	Section 8.4
Provider Survey		Annually April 30th of each year	Section 5.5
Financial Reports **Cover letter to be cc'ed to DMS Contract Compliance Officer**			
Submit all required NAIC reports (Monthly, Quarterly, or Annually) (Copy of cover letter to April Lowery)		Per NAIC requirements	Section 10.6
Submit the final audited HEDIS report to DMS and NCQA		Annually August 31st of each year	Section 5.2

Exhibit B

Passport Health Plan Overview

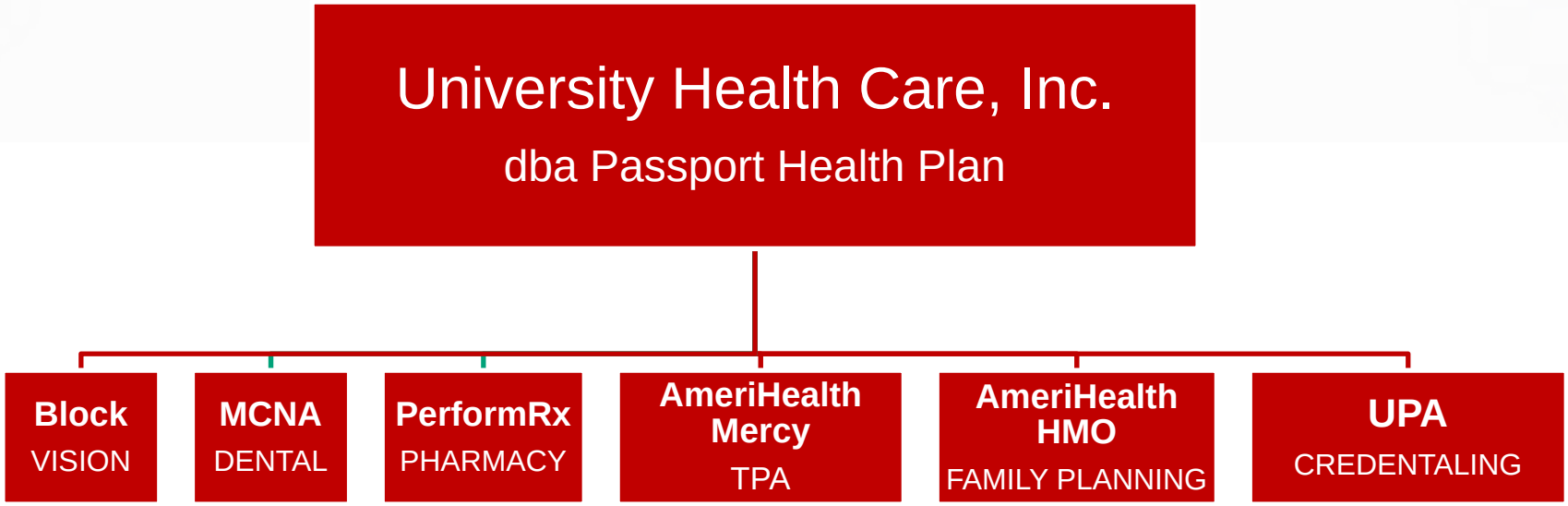
Passport HEALTH PLAN℠

Fact Sheet

- Provider-Sponsored At-Risk HMO
- Collaborative partnership model
  - Commonwealth of Kentucky
  - University Health Care, Inc.
  - Region 3 Partnership Council
- 170,000 members; 16 counties
- Members are served by more than
  - 914 Primary care practitioners
  - 3,977 Specialists
  - 32 Hospitals (includes all hospitals in the region)
  - 462 Other health care providers
- 224 Louisville area employees

Organization Structure

Organization Structure (Subcontractors)



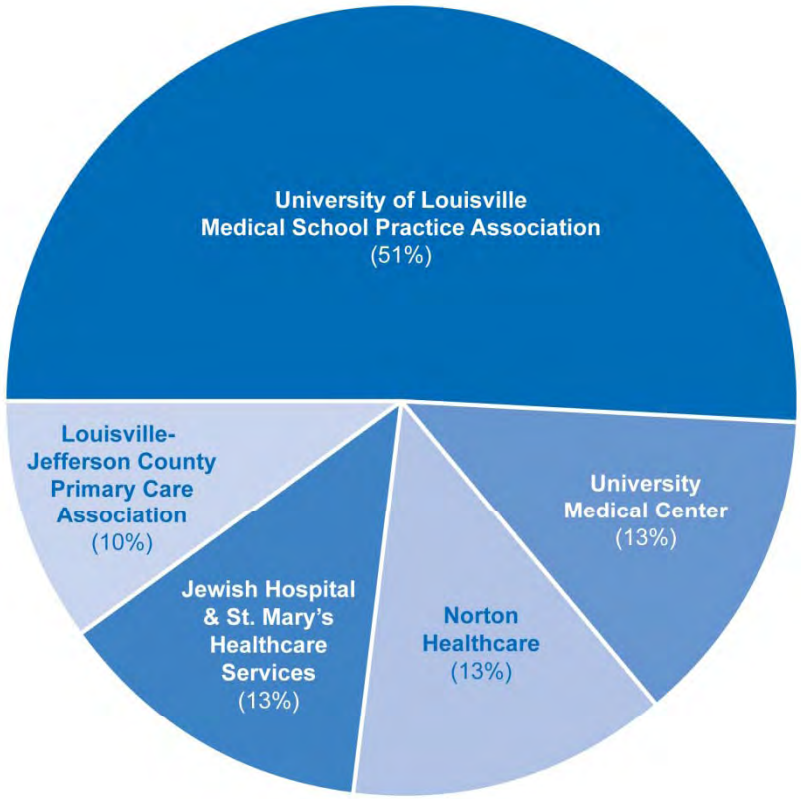
501 (c) (3) Plan Sponsors

William B. Wagner
Chairman of the Board

Mark B. Carter
Chief Executive Officer

Passport has been ranked in the Top 25 Medicaid Health Plans in America by the National Committee for Quality Assurance. Our 2010-2011 ranking in NCQA's Health Insurance Plan Rankings-Medicaid is #15.

Passport has consistently achieved an "Excellent" NCQA accreditation rating



Relationship with State

The Commonwealth of Kentucky has a contract with University Health Care, Inc. (dba Passport Health Plan) to provide services for Medicaid members in 16 counties. The Partnership Council is a segment of the contract. The “Partnership” structure is a key component of the 1115 waiver.

University Health Care, Inc. Board of Directors

Overview

The UHC Board consists of:

Pre-Transition Representatives:

- Sponsor Participation: 16
- Community Participation: 1

Pre-Transition Committees:

- Executive Committee
- Government Relations Committee
- UHC/AMHP "Ad Hoc" Strategy Group
- Finance Committee
- Audit Committee
- Investment Sub-Committee
- Management Agreement Oversight Committee
- Quality Withhold Work Group
- Administrative Withhold Work Group
- Pharmacy Oversight Committee
- Improved Health Outcomes Program

Post-Transition Representatives:

- Sponsor Participation: 9
- Community Participation: 6

Post-Transition Committees:

- Nominating & Board Effectiveness Committee
- Finance Committee
- Investment Sub-Committee
- Grants Committee
- Health Incented Outcomes Program
- Executive Compensation Committee
- Oversight Committee
- Pharmacy Oversight Committee
- Audit Committee
- Compliance Committee

Scope and Oversight

- Protect the Public's Interest
- Enable UHC to Achieve Its Mission
- Oversee the Operations of UHC
- Provide Guidance to UHC Executive Management

Partnership Council … not just a committee

Overview

The Partnership Council:

- Is a non-profit organization established to broadly represent Medicaid providers and Passport Health Plan members
- Assure constituencies have a voice in determining the policies and procedures of Passport Health Plan

Scope

Has responsibility for:

- Reviewing & approving the annual QI and UM Programs & Evaluations
- Recommending policy decisions
- Reviewing and evaluating the results of quality activities
- Instituting actions and overseeing follow up as appropriate

Key Success Factors

- Sole source and provider sponsored
- Partnership model
- Extensive physician/clinician involvement in developing, implementing and managing the plan
- Collaboration with community agencies and health departments
- Member satisfaction and involvement
- Disease management
- Extensive provider network and enhanced reimbursement

Questions?

42 CFR

§438.406 Handling of grievances and appeals.

a) *General Requirements.* In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:
    1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
    2) Acknowledge receipt of each grievance and appeal.
    3) Ensure that the individuals who make decisions on grievances and appeals are individuals-
        i. Who were not involved in any previous level of review or decision-making; and
        ii. Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.
            A. An appeal of denial that is based on lack of medical necessity.
            B. A grievance regarding denial of expedited resolution of an appeal.
            C. A grievance or appeal that involves clinical issues.

b) *Special requirements for appeals.* The process for appeals must:
    1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
    2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)
    3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records during the appeal process.
    4) Include, as parties to the appeal-
        i. The enrollee and his or her representative; or
        ii. The legal representative of a deceased enrollee's estate.

§438.408 Resolution and notification: Grievance and appeals.

a) *Basic rule.* The MCO or PIHP must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

b) *Specific timeframes-*
   1) *Standard disposition of grievances.* For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 days from the day the MCO or PIHP receives the grievance.
   2) *Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected party, the State must establish a timeframe that is no longer than 45 days from the day the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of the section.
   3) *Expedited resolution of appeals.* For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

c) *Extension of timeframes-*
   1) The MCO or PIHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if-
      i. The enrollee requests the extension; or
      ii. The MCO or PIHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.
   2) *Requirements following extension.* If the MCO or PIHP extends the timeframe, it must-for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.

d) *Format of notice-*
   1) *Grievances.* The State must establish the method MCOs and PIHPs will use to notify an enrollee of the disposition of a grievance.
   2) *Appeals.*
      i. For all appeals, the MCO or PIHP must provide written notice of disposition.
      ii. For notice of an expedited resolution, the MCO or PIHP must also make reasonable efforts to provide oral notice.

e) *Content of notice of appeal resolution.* The written notice of the resolution must include the following:
   1) The results of the resolution process and the date it was completed.
   2) For appeals not resolved wholly in favor of the enrollees-
      i. The right to request a State fair hearing, and how to do so;
      ii. The right to request to receive benefits while the hearing is pending, and how to make the request; and
      iii. That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's or PIHP's action.

f) *Requirements for the State fair hearings-*
   1) *Availability.* The State must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than 20 or in excess of 90 days from whichever of the following dates applies-

i. If the State requires exhaustion of the MCO or PIHP level appeal procedures, from the date of the MCO's or PIHP's notice of resolution; or
ii. If the State does not require exhaustion of the MCO or PIHP level appeal procedures and the enrollee appeals directly to the State for a fair hearing, from the date on the MCO's or PIHP's notice of action.

2) *Parties.* The parties to the State fair hearing include the MCO or PIHP as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

§438.410 Expedited resolution of appeals.

a) *General rule.* Each MCO and PIHP must establish and maintain an expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.
b) *Punitive action.* The MCO or PIHP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.
c) *Action following denial of a request for expedited resolution.* If the MCO or PIHP denies a request for expedited resolution of an appeal, it must-
    1) Transfer the appeal to the timeframe for standard resolution in accordance with §438.408 (b) (2);
    2) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar says with a written notice.

§438.414 Information about the grievance system to providers and subcontractors.

The MCO or PIHP must provide the information specified at §438.10 (g) (1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

Exhibit D

Board Statement

University Healthcare, Inc. d/b/a Passport Health Plan is a provider-sponsored managed care organization, and its Board of Directors includes individuals appointed by the sponsoring providers. These members of the Board have a potential conflict of interest with respect to every decision of the Board that will have an impact on the providers that appointed them to the Board. These members of the Board may participate in the Board discussion and cast votes on such actions, but their participation and voting must be based on their fiduciary duty to Passport, not on the interests of the providers that appointed them to the Board. The Board may also be asked to make decisions that would cause a member of the Board to have a personal financial conflict of interest, instead of such a provider-based conflict of interest. Any member of the Board who has a personal conflict of interest must fully disclose to the other members of the Board the basis of his or her conflict, and must leave the meeting during the discussion and voting on such action.

Exhibit E

AmeriHealth Mercy Health Plan
Cost Allocation Methodology

Overview

AmeriHealth Mercy utilizes an activity-based costing (ABC) approach to determine its cost for each line of business. ABC traces costs from departments to activities and ultimately to a line of business using various cost drivers. Cost drivers are factors which directly impact the work effort or expense of performing a particular activity. For example, the number of calls received in a call center and average duration of a call directly impacts how many customer service representatives are needed to answer calls. By utilizing cost drivers instead of general allocations, costs are more accurately traced to each line of business.

Cost Model Methodology - Activities and Cost Drivers

Each month, the general and administrative expenses are loaded into an ABC cost model to be allocated to each line of business. The model takes departmental costs, groups them into activities, and then allocates the activity costs to each line of business. Activities in the model were defined through interviews between the finance department and the various departments throughout the company. Activities and drivers are reviewed and updated annually or if significant process changes occur. Activities fall into three general categories:

Support Activities – Indirectly support operational activities and/or other departments. Examples include Human Resources, Facilities, and IT Technical Support.

Operational Activities – Key activities of the organization which are performed for a line of business. Examples include claims processing and customer service call center.

Corporate Management & Business Sustaining Activities – Activities associated with the overall management and strategy of the organization. Includes major investments to keep the company operational and competitive. Examples include Legal and investments in HIPAA.

Once the activities are defined, costs are allocated from the departments to the activities based on resource drivers. Resource drivers are factors that impact the work effort or expenses associated with an activity. The most common resource driver is number of hours or FTE's utilized for each activity. Note that if a particular expense can be directly identified with a line of business, the cost is excluded from the allocation and is charged directly to the line of business.

Cost drivers are used to allocate activity costs to each line of business. A cost driver is a factor that represents the frequency and intensity of work performed, such as the quantity of paper claims received. First support activities are reallocated to other departments or operational activities using corresponding cost drivers. Next, cost drivers are used to allocate the operational activity costs to each line of business.

AmeriHealth Mercy Allocation Hierarchy

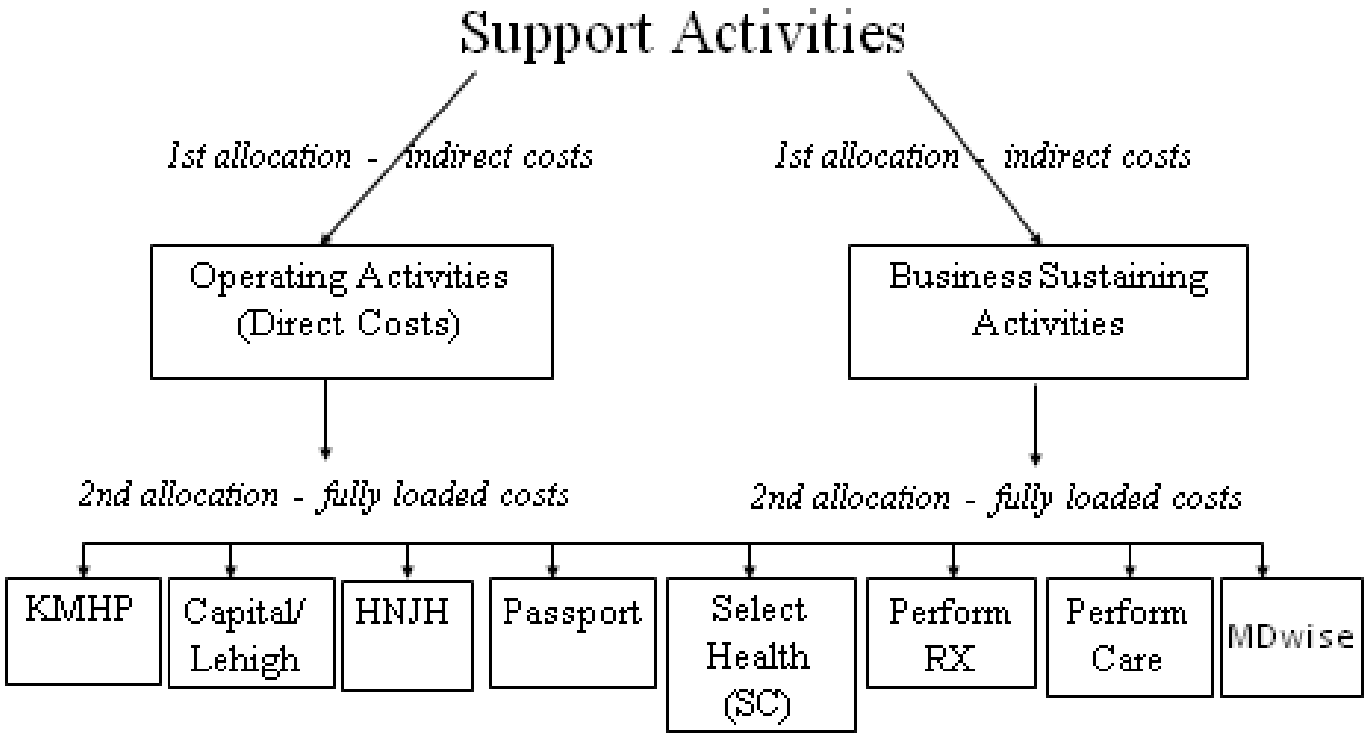


Exhibit F

T_Unclean_Claim_Codes

Passport Health Plan

EXCD_ID	EXCD_SHORT_TEXT	Clean_or_Unclean
106	Billed with Invalid Bill Type	Unclean
107	Rending Provider not registered	Unclean
108	Invalid Procedure/Modifier/POS combo	Unclean
114	Bill Type Missing	Unclean
115	Missing Revenue Code for Bill Type	Unclean
116	Missing HCPC Code for Bill Type	Unclean
118	Invalid Patient Status for Bill Type	Unclean
119	Missing Discharge Hour for Bill Type	Unclean
120	Provider Billed in Error	Unclean
126	Missing/Illegible procedure/Revenue Code	Unclean
143	Members Age not valid for diagnosis code	Unclean
145	Please submit the primary diagnosis	Unclean
146	Attending Physician ID/Name Missing	Unclean
147	Incorrect Tax Id Number Submitted	Unclean
151	Prior Authorization Required	Unclean
160	Member Sex Not Valid for Diagnosis Code	Unclean
161	Invalid or Zero Units Submitted	Unclean
162	DOS cannot be greater than received	Unclean
163	Not Enrolled on Date of Service	Unclean
164	Dates and/or Serv Outside Referr/Auth	Unclean
166	Auth/Notification/Referral not obtained	Unclean
167	Resubmit with EOB from primary carrier	Unclean
168	No Show	Unclean
173	Service not covered for reported Dx	Unclean
174	Code not payable for provider specialty	Unclean
175	Entry error, if applicable, reprocessed	Unclean
176	DOS not between admit and discharge	Unclean
177	Diagnosis Not Effective for Date of Serv	Unclean
178	Resubmit with more specific CPT code	Unclean
180	Resubmit w/Registered Billing Provider	Unclean
183	Rendering NPI not for Provider ID Box 31	Unclean
352	Incorrect Subscriber ID	Unclean
356	Incorrect Provider/PCP Data	Unclean
575	Resubmit with Medicaid RID, Former PE	Unclean
A52	Primary/Sec Diagnosis POA Error	Unclean
CBI	COB Information not received	Unclean
CBN	Primary Carrier Information Required.	Unclean
G01	16:Group ID not payable	Unclean
G09	I48: Incorrect Secondary Liability	Unclean
G24	47: Incorrect Diagnosis Code Entered	Unclean
I02	B12:Illegible Records Submitted	Unclean
I04	Correct NDC Code Req	Unclean
I05	Invalid/Inapp/Del Code, Mod or Desc	Unclean
I06	Itemized Bill/DOS/Charges/Invoice Req	Unclean
I07	Invalid/Inapp/Del Code, Mod or Desc	Unclean
I08	Diagnosis inv/missing/del 4th or 5th	Unclean
I09	Diag Inv /Missing/Deleted/Req 4th/5th	Unclean
I10	ECode Cannot Be Used As Primary Diag	Unclean

Exhibit F

T_Unclean_Claim_Codes

EXCD_ID	EXCD_SHORT_TEXT	Clean_or_Unclean
I11	Clm Pend: EOB from prim carrier req	Unclean
I12	Claim w/o Phys name or number	Unclean
I13	EOB/attach illeg/incomplete	Unclean
I14	Invalid/missing Revenue Code	Unclean
I38	Need Newborn Number	Unclean
I48	Resub Primary Carrier/Appeal Process	Unclean
I49	B18: Resub claim with more specific code	Unclean
I68	Invalid place of service for procedure	Unclean
I73	EPSDT Form was Incomplete	Unclean
I99	MAID Missing or Invalid	Unclean
IR1	Implant Invoice Required	Unclean
ISS	7:Invalid Sex For Service Rendered	Unclean
J65	Externally Priced Claims	Unclean
J71	Invalid Gender for DX	Unclean
K66	Primary/Sec Diagnosis POA Error	Unclean
L68	Itemized bill/invoice/med rec rec'd	Unclean
M71	OBSV Billed as IP	Unclean
M72	I/P Billed as OBSV	Unclean
M73	Name/DOS on case notes do not match	Unclean
M74	Member has Multiple Insurances	Unclean
MLN	16:Please submit primary dx	Unclean
N14	Invalid Gender for Procedure	Unclean
N17	Invalid place of service for procedure	Unclean
N19	Invalid Diagnosis for Procedure	Unclean
N27	Invalid Modifier Disallow	Unclean
N76	Invalid Proc Modifier Combination	Unclean
N77	Invalid Modifier	Unclean
N78	Invalid Diagnosis Code	Unclean
R01	No Precert/Authorization or Referral	Unclean
R08	Diagnosis inv/missing/del 4th or 5th	Unclean
R10	Not Enrolled on Date of Service	Unclean
R45	Complete Med Records Required	Unclean
R53	Services were not Provided	Unclean
R59	62:Referral Expired	Unclean
R60	Dates and/or Servs Outside Ref/Auth	Unclean
R69	16:Invalid or Zero Units Submitted	Unclean
R72	Provider was Not Member's PCP	Unclean
R84	Resub W/ Individual Provider Name/Number	Unclean
R86	Invalid/Missing Rev Code on Claim	Unclean
R91	Inappropriate Coding for Contract/Agree	Unclean
R94	Prov # Submitted via EDI Incorrect/Termd	Unclean
R95	Claim without Physician Name	Unclean
R96	EOB/Attachmnts were Incomplete/Illegible	Unclean
R97	DOS Cannot be Greater than Received Date	Unclean
S1A	31:No eligibility found	Unclean
S2	Date requested < Subscriber's Birth D	Unclean
S20	Date req. prior to Member Orig. Eff D	Unclean
S21	26:Date req prior to Group Effective Dat	Unclean
S22	26:Date req prior to subgroup orig ef dt	Unclean
S23	Date req. Prior to Subscriber Eff Dt.	Unclean
S3	Date requested < Member's Birth Date	Unclean

Exhibit F

T_Unclean_Claim_Codes

EXCD_ID	EXCD_SHORT_TEXT	Clean_or_Unclean
SN	31:Non-eligible member	Unclean
SO	27:Termination - ineligible	Unclean
ST	Termination	Unclean
UAS	6:Patient Under Age For Service Rendered	Unclean
X01	No Precert/Authorization or Referral	Unclean
X02	Illegible records submitted	Unclean
X04	Correct NDC Code required	Unclean
X05	Invalid/Innap/del code, mod or desc	Unclean
X06	Itemized Bill/DOS/Charges/Invoice Req	Unclean
X08	Diag inv/missing/del 4th or 5th	Unclean
X09	22:M/C A not eff/exhaust';M/C B EOB need	Unclean
X10	Not Enrolled on Date of Service	Unclean
X11	Clm Pend: EOB from prim carrier req	Unclean
X12	Motor Vehicle Accident - Auto Primary	Unclean
X13	Workers Comp Primary Carrier	Unclean
X17	Missing/IllegibleValueCode or Amount	Unclean
X38	Need Newborn Member Number	Unclean
X44	16:Resubmit w/ICD/9 princ proc code/date	Unclean
X45	Complete med records required	Unclean
X53	Services were not Provided	Unclean
X60	Dates and/or ServicesOutsideRef/Auth	Unclean
X62	Invalid or Missing DRG	Unclean
X67	Discrep with Level of Care-AppealReq	Unclean
X68	Invalid or Zero Units Submitted	Unclean
X69	Attending Phys ID/Name Missing/Invalid	Unclean
X73	EPSDT Form was Incomplete	Unclean
X77	Incorrect Provider/TIN ID # Submitted	Unclean
X83	Mother's Bill not Received; Refile	Unclean
X84	Please Obtain Individual Provider ID #	Unclean
X86	Invalid/missing revenue code	Unclean
X91	Inappropriate Coding for Contract/Agree	Unclean
X94	Prov # Submitted via EDI Incorrect/Termd	Unclean
X95	Claim submitted without phys name	Unclean
X96	EOB/attach illeg/incomplete	Unclean
X97	DOS Cannot be Greater than Received Date	Unclean
X98	Inappropriate Coding for Contract/Agree	Unclean
Z11	148:EOB from primary carrier required	Unclean
Z16	148:Resubmit with Medicare EOB	Unclean
Z38	Missing/Illegible Procedure/Revenue Code	Unclean
Z41	Missing/Illegible ICD-9 procedure code	Unclean
Z48	ResubPrimaryCarrier/Appeals Process	Unclean
Z54	Inappropriate Claim Form For Professional Services	Unclean
Z55	Service Performed Not Valid for Place of Service Code Submitted	Unclean
Z72	OBSV Billed as IP	Unclean
Z74	Name/DOS on case notes do not match	Unclean
Z75	Member has Multiple Insurances	Unclean
Z76	Incorrect Provider/TIN ID Submitted	Unclean
Z86	I/P Billed as OBSV	Unclean
Z92	Invalid or Missing Place of Service	Unclean
Z95	Invalid/Inapp/Del Code, Mod or Desc	Unclean
Z99	Code Not payable for ProviderSpecialty	Unclean

Exhibit F

T_Unclean_Claim_Codes

EXCD_ID	EXCD_SHORT_TEXT	Clean_or_Unclean
ZZ1	Supporting documentation missing/invalid	Unclean
ZZ2	Supporting documentation missing/invalid	Unclean

Exhibit G

Facets Claims Processing

The claim adjudication routine is the cycle in which a claim is processed. During claims adjudication (hospital or medical), Facets will make certain determinations and access various routines, such as Eligibility, Provider/PCP/Network, and Pricing. Listed below, in order, are the routines Facets performs during claims adjudication which may directly relate to prevention of FWA.

Eligibility

During claims adjudication, Facets eligibility logic will check for valid eligibility and the benefits associated with the Subscriber. In the event eligibility cannot be validated, the following conditions will be applied in claims processing:

- If the member is ineligible, Facets will deny the claim.
- If the eligibility row is not found, Facets will display an error message and adjudication is stopped.
- If the eligibility check produces a warning message, users will be able to continue processing and will have to Pend or Accept depending on the security level of the warning message.

Provider/PCP/Network determination

1. Facets will first determine if a servicing provider on a claim is the member's PCP. Facets will check whether the servicing provider is on the member's member/provider relationship record.
2. If not, Facets will read up the provider related entity relationship hierarchy to determine if the servicing provider belongs to a Provider Group and determine if the group is on the member's record.
    a. Facets will determine if the servicing provider is one of the following:
        i. Covering for the member's PCP.
        ii. A secondary provider.
        iii. A PCP network provider.
        iv. A global provider.
        v. A specialist provider.
        vi. A non-participating provider.
3. If no match is found, Facets will default to the product pricing for the servicing provider.

Service Definition

During claims adjudication, Facets will obtain a Service Definition which will in turn determine a price. If a provider agreement is found, the Service Definition will be retained from the Agreement. If the provider does not have an agreement, the Service Definition will be obtained from the Product's record. The Service Definition record on the agreement allows the user to establish different referral, pre-authorization, pricing, capitation and risk withholding requirements to be applied to all providers under this agreement.
The Service Definition record on the product will point to the default or out of network pricing for that product.

Duplicate Editing/Claims History check

Rules are defined for what constitutes a definite or possible duplicate claim or line item when processing. Numerous groups of claim parameters can be configured and when linked together, will be matched against the member's claim history to determine whether the current claim is a duplicate of a prior submission. Users are able to select whether they want to include only the current claim (i.e., the line items on the current claim), or actual history claims (i.e., prior submissions), or both. In claims adjudication, Facets will perform a duplicate check for each claim line. If an exact duplicate is found, Facets will disallow the claim line and go to the next. If a claim line is not an exact duplicate, Facets will continue the claim adjudication flow process.

Managed Care edits

Facets then uses the claim's service provider or facility ID, procedure code, type of service and diagnosis code to determine if referral and/or pre-authorization requirements exist for the line item of the claim.

1. If the **Service Provider or Facility's Pre-authorization Required** field on the Practitioner or Facility record is populated with:
   - *No Services*, Facets bypasses the pre-authorization requirements at all other levels and assumes that pre-authorizations are **not** required.
   - *All Services*, Facets assumes that pre-authorizations are required for all services regardless of the pre-authorization indicators set in any other application.
   - *Not Applicable*, Facets proceeds to the routine as identified in 2 through 5 below.
2. If the **Pre-authorization Required** box is checked for a procedure code Facets checks for matching pre-authorizations.
3. If the **Pre-authorization Required** box for a diagnosis code is checked Facets checks for pre-authorizations. If the **Referral** and/or **Pre-authorization Required** boxes are checked for a procedure code Facets checks for matching referrals and/or pre-authorizations.
4. If the **Referral** and/or **Pre-authorization Required** boxes for a Type of Service are checked Facets checks for matching referrals and/or pre-authorizations.
   Facets' provides an option to waive the referral requirements for the PCP-ordered services. In this instance, the PCP must be identified as the referring provider on the claim.

Clinical Editing

During claims adjudication, Facets obtains clinical editing criteria. Clinical Edits can be customized, services set to bypass, disallow or generate a warning message when an edit is encountered. In the case of subset and redundant edits, charges will be combined from the edited procedure line items into the primary procedure line item. In the case of secondary edits, the secondary penalty percentage will be priced against the calculated allowable priced amount of the line item. This refers to the priced amount of the line, not the charges.

The Facets claims processing system performs over a million clinical edits, categorized into the following major groups:

- Assistant Surgeon
- Cosmetic
- MUE Edits
- Diagnosis code edits
- Age Edits
- Follow up Days
- Invalid Procedure Code
- NCCI Edits (Subset and Redundant)

Pricing

During claims adjudication, Facets will edit the Procedure/Revenue codes from the claim against the Supplied data tables. Service IDs are created by mapping groups of CPT-4/Revenue codes by use of conversion tables. The Service ID represents the definition by which the service provided will be priced. Particular tables establish the specific rules and parameters set to adjudicate claims.

Pricing Methods

Several different types of pricing are available for selection in the Pricing Method field. Depending on which method is selected, the user will have to complete different fields in the Rules and Prefixes group boxes. Note that any pricing established at the provider agreement level will be used instead of what has been loaded on the Product.

Users can also choose to always pay the amount loaded on the provider's pricing profile (linked to the provider agreement) which includes fee schedule, DRG, or conversion factor, regardless of whether the profile amount is higher than the amount billed.

Exhibit G

Service Rules, Deductibles, Limits, Penalties

Service rules help the system adjudicate payment based on several parameters. A Service ID may have multiple service rules applied to it. A Service Rule establishes the calculation method of the service, the claims processing edits to be applied, penalty types and amounts, and service tiers. At a high level, Facets will determine how Services will be priced. Will Medical claims be priced by reasonable and customary (R&C) rates or Fee Schedules? Will Room and Board be reimbursed by Per Diem/Per Case or DRG rates?

Deductibles

The Deductible Rules are used to establish the amount which must be paid by the member, either on a plan year, lifetime or per confinement basis, before benefit payment begins. Deductible Rules can vary based on the provider, pre-authorization, and referral guidelines entered. Rules for deductible can be established based on individuals, families or a combination of family and individual.

Limits

The Limit Rules are used to define each benefit limitation or stoploss (out of pocket maximum) applicable. Each Limit Rule can be applicable to selected benefit types, based on amounts paid or allowed, or based on the number of services paid, applied during a plan year or over the member's lifetime. A Limit is a dollar amount or number of counters that, once reached, will result in no further benefits being reimbursed. Limits can be established which apply to all services or only to selected services or related diagnoses. Limits can be at the member level or the family level. Limits can be based on a dollar amount or a number of counters.

Penalties

Users can establish service penalties that are applied during claims processing. Some examples of when penalties can be applied are: UM guidelines were not followed, out of network situations, or to discourage providers from performing specific types of service. Users can choose to apply the penalty as a flat amount, or a percentage, can select to apply the penalty to the allowable or paid amount, and can enter the amount which represents the maximum penalty amount to be taken.

Overrides

During claims processing, users are able to override copays and coinsurance on each line item. This becomes an issue when multiple tiers are accessed. When a copay override is performed, Facets first determines the coinsurance rate based on the allowable (allowed minus deductible and copay) divided by the original coinsurance amount. The new copay is subtracted from the allowed amount, and the sum is multiplied by the coinsurance rate computed above.

Disallows

COB

Facets' provides users with the following COB Calculation Methods:

- **Charges**
  The total charges submitted for the Claim.
- **Facets Allowable**
  This is the amount available after the pricing calculation and service payment reductions.
- **Higher Allowable**
  The higher of the other carrier's allowable amount or Facets' allowable amount will be used as the higher allowable amount.
- **Other Carrier Allowable**
  The other carrier's allowable amount (whether it is higher or lower than the Facets' allowable amount). If the other carrier allowable amount is zero, Facets calculates COB based on the Facets allowable amount.
- **Facets Allowable + Disallow Entered**
  The sum of Facets' allowable amount plus any disallow amount entered in the Add Disallow to COB Calculation dialog in the Claims Processing application.
- **Offset**
  The amount defined and displayed as the benefit amount in Facets less the other carrier paid amount.

Exhibit G

Processing Control Agent (PCA)

The Facets adjudication routine optionally reads information stored in the PCA application at the end of the routine. Specific rules based on precise criteria are set here to Deny a claim or Pend a claim for manual review.

Exhibit H

National Association of Insurance Commissioners & The Center for Insurance Policy and Research

October 27, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Madame Secretary:

On behalf of the National Association of Insurance Commissioners (NAIC), we are pleased to transmit the attached uniform definitions and standard methodologies for medical loss ratios, as required by Section 2718 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act (PPACA). These recommendations were unanimously approved by our fellow commissioners on October 21st, and are the result of extensive public debate and consideration through an open and transparent process.

It has been our goal to complete our work in a manner that is faithful to the provisions of PPACA. While we believe that we have succeeded in realizing this goal, we continue to have concerns about the potential for unintended consequences arising from the medical loss ratio. As we noted in our letter of October 13th, consumers will not benefit from higher medical loss ratios if the outcome is destabilized insurance markets where consumer choice is limited and the solvency of insurers is undermined. This is of particular concern in the period before guaranteed issue and Exchanges are implemented in 2014, as those who lose coverage may be unable to find or afford other coverage. We reiterate our request that your Department give deference to the analysis and recommendations of state regulators when determining how the new requirements will be implemented in a destabilized market.

As we also noted in our October 13th letter, we are very concerned about the impact the medical loss ratio requirement could have on the ability of insurance agents and brokers to continue assisting health insurance consumers at a time of rapid changes that makes their role even more essential. The NAIC has created a working group to coordinate with your Department to ensure that the vital role of agents and brokers is preserved, especially during years leading up to 2014. We look forward to working with you on this important issue as soon as possible.

Best Regards,

Jane Cline
West Virginia Insurance Commissioner
NAIC President

Susan Voss
Iowa Insurance Commissioner
NAIC President-Elect

Kevin McCarty
Florida Insurance Commissioner
NAIC Vice-President

Kim Holland
Oklahoma Insurance Commissioner
NAIC Secretary-Treasurer

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New Hampshire Insurance Commissioner
NAIC Immediate Past President

Sandy Praeger
Kansas Insurance Commissioner
NAIC Health Insurance & Managed Care (B) Committee Chair

EXECUTIVE OFFICE	444 N. Capitol Street, NW, Suite 701	Washington, DC 20001-1509	p | 202 471 3990	f | 816 460 7493
CENTRAL OFFICE	2301 McGee Street, Suite 800	Kansas City, MO 64108-2662	p | 816 842 3600	f | 816 783 8175
SECURITIES VALUATION OFFICE	48 Wall Street, 6th Floor	New York, NY 10005-2906	p | 212 398 9000	f | 212 382 4207

www.naic.org

REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED METHODOLOGIES FOR CALCULATION OF THE MEDICAL LOSS RATIO FOR PLAN YEARS 2011, 2012 AND 2013 PER SECTION 2718 (b) OF THE PUBLIC HEALTH SERVICE ACT

Table of Contents

Section 1. Short Title

This Regulation shall be known and may be cited as the Patient Protection and Affordable Care Act Medical Loss Ratio Regulation.

Section 2. Purpose

The purpose and intent of this Regulation are to promulgate uniform definitions and a standardized methodology for calculating the medical loss ratio, as legislated by Section 2718 (b) of the Public Health Service Act and the Patient Protection and Affordable Care Act.

Section 3. Definitions

A. As used in this Regulation and directed by PPACA to be defined by the NAIC:

(1) "Affiliate" means the statutory accounting definition for affiliate as contained in the then current NAIC Accounting Practices and Procedures Manual.

(2) "Clinical services" means "incurred claims," as defined in 3A (8).

(3) "Earned premium" means the statutory accounting definition for premium for health insurance coverage on a direct basis as contained in the then current NAIC Accounting Practices and Procedures Manual, plus or minus any portions of premium associated with group conversion privileges the issuer transfers between Group and Individual lines of business in its Annual Statement accounting, plus or minus any experience rating refunds paid or received, except as follows:

(a) For purposes of this definition, experience rating refunds shall not include any rebates paid pursuant to Sections 8 or 9 notwithstanding the definition in 3B (10).

(b) Earned premium for policies that were originally issued by one entity and later assumed by another entity via assumption reinsurance are to be treated as direct earned premium for the assuming entity's medical loss ratio rebate calculations and excluded from the ceding entity's medical loss ratio rebate calculations.

(c) If a block of business was subject to indemnity reinsurance and administrative agreements, effective prior to the effective date of PPACA (March 23, 2010), such that the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block, then the assuming entity and not the ceding entity should report the reinsured earned premium as part of its medical loss ratio rebate calculations.

(4) "Expenses to improve health care quality" means those expenses as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010.

(5) "Federal and State taxes and licensing or regulatory fees" means those taxes and licensing or regulatory fees, as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit, as adopted by the National Association of Insurance Commissioners on August 17, 2010.

(6) "Health plan" means health insurance coverage offered by a health insurance issuer as such terms are defined in the Public Health Service Act (including a grandfathered health plan) unless such coverage is an excepted benefit as provided for in the Public Health Service Act.

(7) "Incurred loss" means "incurred claims," as defined in 3A (8).

(8) "Incurred claims" means claims for health insurance coverage on a direct basis incurred during the applicable plan year, plus unpaid claim reserves associated with claims incurred during the applicable plan year, plus the change in contract reserves, plus the claims-related portion of reserves for contingent benefits and lawsuits, plus any experience rating refunds paid or received, and reserves for experience rating refunds. This definition is consistent with the statutory accounting definition contained in the then current NAIC Accounting Practices and Procedures Manual and the definition in Appendix C derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010. If there are any group conversion charges for a health plan, the conversion charges should be subtracted from the incurred claims for the aggregation that includes the conversion policies and this same amount should be added to the incurred claims for the aggregation that provides coverage that is intended to be replaced by the conversion policies. Additionally, if the issuer transfers portions of earned premium associated with group conversion privileges between Group and Individual lines of business in its Annual Statement accounting, these amounts should be added to or subtracted from incurred claims.

(9) "Individual health plan" means a health plan offered to individuals in the individual market as such term is defined in the Public Health Service Act, but does not include short-term limited duration insurance as defined in the Public Health Service Act.

(10) "Large group health plan" means a health plan offered in the large group market as such term is defined in the Public Health Service Act.

(11) "Medical loss ratio rebate" means the quantity specified in Section 2718 (b) (1) (A) of the Public Health Service Act.

(12) "Plan year" means "calendar year" as defined in Section 3B (3).

(13) "Small group health plan" means a health plan offered in the small group market as such term is defined in state law in accordance with the Public Health Service Act.

B. As used in this Regulation:

(1) "Blended rates" means cross-subsidized rates charged for health insurance coverage provided by a single employer through two or more affiliates.

(2) "Business sold through an association" means a policy issued to an association or to a trust or to the trustees of a fund established, created or maintained for the benefit of members of one or more associations.

(3) "Calendar year" means the period of time from January 1, YYYY to December 31, YYYY.

(4) "Claims unpaid" means claims reported and in the process of adjustment, percentage withholds from payments made to contracted providers, incurred but not reported claims, and recoverables for anticipated coordination of benefits and subrogation.

(5) "Contract reserves" means reserves that are established which, due to the gross premium pricing structure at issue, account for the value of the future benefits at any time exceeding the value of any appropriate future valuation net premiums at that time. Contract reserves should not include premium deficiency reserves. Contract reserves should not include reserves for expected MLR rebates.

(6) "Credibility adjustment" means the adjustment to account for random statistical fluctuations in claims experience for smaller plans.

(7) "Direct paid claims" means claim payments before ceded reinsurance and excluding assumed reinsurance except as follows: Paid claims for policies that were originally issued by one entity and later assumed by another entity via assumption reinsurance are to be treated as direct paid claims for the assuming entity's medical loss ratio rebate calculations and excluded from the ceding entity's medical loss ratio rebate calculations. If a block of business was subject to indemnity reinsurance and administrative agreements, effective prior to the effective date of PPACA (March 23, 2010),

such that the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block, then the assuming entity and not the ceding entity should report the reinsured claims as part of its medical loss ratio rebate calculations. Claims payments recovered through fraud reduction efforts can be added back to claims in the medical loss ratio calculation, up to the amount of expenses expended to reduce fraud.

(8) "Dual contract" means the case where a small or large group policyholder purchases in-network coverage from one issuer and out-of-network coverage from a different issuer that is an affiliate of the first issuer.

(9) "Dual option" means the case where a small or large group policyholder purchases two or more different health plans from two or more affiliates.

(10) "Experience rating refund" means retrospective premium adjustments arising from retrospectively rated contracts as determined by the Statements of Statutory Accounting Principles 66, plus any incurred state premium refunds. If the 2012 experience is not fully credible, the experience rating refund for the plan year 2012 calculation shall also include any rebate paid pursuant to Section 8. The experience rating refund for the plan year 2013 calculation shall also include any rebates paid pursuant to Sections 8 and 9.

(11) "Fully credible," as it relates to experience, means experience generated by 75,000 or more life years.

(12) "Group conversion charges" means the portion of earned premium allocated to providing the privilege for a certificate holder terminated from a group health plan to purchase individual health insurance without providing evidence of insurability.

(13) "Incurred medical pool incentives and bonuses" means arrangements with providers and other risk sharing arrangements as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010.

(14) "Life years" means the number of member months divided by 12.

(15) "Minimum medical loss ratio standard" means the percentage determined in accordance with Section 2718 (b) (1) (A) (i) or (ii) of the PHSA. In the case of minimum medical loss ratio standards that are not constant over an averaging period, the minimum standard will be the average of the standards used in each year weighted by earned premium less Federal and State taxes and licensing or regulatory fees.

(16) "Net healthcare receivables" means the healthcare receivable assets as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010.

(17) "Non-credible," as it relates to experience, means experience generated by less than 1,000 life years.

(18) "Partially credible," as it relates to experience, means experience generated by at least 1,000 life years but less than 75,000 life years.

(19) "PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

(20) "PHSA" means Public Health Service Act.

(21) "Policyholder" means any entity that has entered into a contract with a health insurance issuer to receive health insurance coverage as defined in Section 2791 (b) of the PHSA.

(22) "Reserves for experience rating refunds" means an estimate of amounts due but unpaid under a retrospectively rated funding arrangement or due but unpaid for a state premium refund.

(23) "Situs of the contract" means the jurisdiction in which the contract is issued or delivered as stated in the contract.

(24) "State premium refund" means any rebate or refund of premium payable under state law as a result of state loss ratio requirements which need not be identical to the federal requirements in such matters as minimum percentage, definition of claim, definition of premium, aggregation, timing of calculation, etc.

(25) "Unearned premium reserves" means reserves that are established to account for that portion of the premium paid in the plan year that is intended to provide coverage during a period which extends beyond the plan year.

(26) "Unpaid Claim Reserves" means reserves and liabilities established to account for claims unpaid.

C. All terms defined in this Regulation, whether in this Section or elsewhere, shall be construed, and all calculations provided for by this Regulation shall be performed, as to exclude the financial impact of any of the rebates provided for in Sections 8, 9, and 10. Notwithstanding the foregoing, rebates shall be reflected as specifically provided for in the instructions in Appendix A for Line 7 of the Rebate Calculation Supplemental Form.

Section 4. Applicability and Scope

The provisions of this Regulation concerning the calculation and payment of medical loss ratio rebates shall apply to any health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) as provided for in Section 2718 of the PHSA for plan years 2011, 2012 and 2013.

Section 5. Levels of Aggregation for Medical Loss Ratio Rebate Calculations

A. Medical loss ratios shall be calculated at the licensed entity level within a state, with experience allocated to states based on the situs of the contract, except that for individual business sold through an association, the allocation shall be based on the

issue state of the certificate of coverage and for employer business issued through a group trust, the allocation shall be based on the location of the employer. Experience shall be further subdivided into

(1) Individual health plans;

(2) Small group health plans;

(3) Large group health plans.

B. Pursuant to Section 1312(c)(3) of PPACA, a state may require the individual and small group insurance markets within a state to be merged if the State determines appropriate. In this case, rebates shall be calculated at the licensed entity level within a state, further subdivided into

(1) Individual and small group health plans;

(2) Large group health plans.

C. Plans classified as dual contract may be aggregated as follows:

(1) Experience may be treated as if it were all generated by the plan provided by the in-network issuer.

(2) An issuer that chooses this method of aggregation shall apply it for a minimum of three plan years.

(3) For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

Section 6. Frequency and Timing of Medical Loss Ratio Rebate Calculations and Rebate Payments

A. Medical loss ratios shall be calculated annually by all health insurance issuers that provide coverage through one or more health plans that are subject to Section 2718 of the PHSA.

B. Medical loss ratios shall be calculated using data as of December 31 of the plan year except for incurred claims which shall be restated as of March 31 of the year following the plan year.

C. Medical loss ratios shall be reported to the applicable state(s) by May 31 of the year following the plan year using the appropriate reporting format in Appendix A.

D. Rebates shall be paid annually by June 30 of the year following the plan year.

Section 7. Credibility Adjustments to Medical Loss Ratio

A. Plan year 2011

(1) A credibility adjustment is not applicable to any aggregation as defined in Section 5 that is either non-credible or fully credible based on plan year 2011 life years.

(2) The credibility adjustment for any aggregation as defined in Section 5 that is partially credible based on plan year 2011 life years is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B.

(a) The Table 1 factor is determined using plan year 2011 life years for the aggregation. The Table 1 factor for a value that is between two life year categories is calculated by linearly interpolating the value between the lower and upper life year categories.

(b) The Table 2 factor may be determined using the plan year 2011 average plan deductible, weighted by life years, for the aggregation. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.

B. Plan year 2012

(1) A credibility adjustment is not applicable to any aggregation as defined in Section 5 that is fully credible based on plan year 2012 life years or based on the sum of life years for plan years 2011 and 2012.

(2) If the sum of life years for plan years 2011 and 2012 is non-credible for any aggregation as defined in Section 5, a credibility adjustment is not applicable.

(3) The credibility adjustment for any aggregation as defined in Section 5 that is partially credible based on the sum of life years for plan years 2011 and 2012 is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B.

(a) The Table 1 factor is determined using the sum of plan year 2011 and plan year 2012 life years for the aggregation. The Table 1 factor for a value that is between two life year categories is calculated by linearly interpolating the value between the lower and upper life year categories.

(b) The Table 2 factor may be determined using the average plan deductible for plan year 2011 and plan year 2012 combined, weighted by life years, for the aggregation. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.

C. Plan year 2013

(1) A credibility adjustment is not applicable to any aggregation as defined in Section 5 that is either fully credible or non-credible based on the sum of life years for plan years 2011, 2012, and 2013.

(2) The credibility adjustment for any aggregation as defined in Section 5 that is partially credible based on the sum of life years for plan years 2011, 2012, and 2013 is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B.

(a) The Table 1 factor is determined using the sum of life years for plan years 2011, 2012, and 2013 for the aggregation. The Table 1 factor for a value that is between two life year categories is calculated by linearly interpolating the value between the lower and upper life year categories.

(b) The Table 2 factor may be determined using the average plan deductible for plan year 2011, plan year 2012 and plan year 2013 combined, weighted by life years, for the aggregation. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.

Section 8. Medical Loss Ratio Rebate Calculation for Plan Year 2011

A. A rebate is not payable for any aggregation that is non-credible based on plan year 2011 life years.

B. If, for any level of aggregation as defined in Section 5, 50% or more of the total earned premium for 2011 is attributable to policies newly issued in 2011 with less than 12 months of experience in 2011, the experience of these policies may be excluded from the medical loss ratio calculation for plan year 2011. The excluded experience shall be added to the experience used to calculate the medical loss ratio for plan year 2012. For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

C. The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality.

(1) Incurred claims are those with incurral dates from January 1, 2011 to December 31, 2011, less any claims incurred in 2011 that are to be deferred to the plan year 2012 calculation.

(2) Expenses to improve health care quality are for the period from January 1, 2011 to December 31, 2011, less any expenses to improve health care quality from the 2011 plan year that are to be deferred to the plan year 2012 calculation.

D. Numerator adjustment for insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2011, and shall apply to all groups as described in D(1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2011.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

E. Numerator adjustment for dual option insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides dual option insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2011, and shall apply to all groups as described in E(1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2011.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

F. The denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums less Federal and State taxes and licensing or regulatory fees.

(1) Earned premiums are for the period from January 1, 2011 to December 31, 2011, less any premiums earned in the 2011 plan year that are to be deferred to the plan year 2012 calculation.

(2) Federal and State taxes and licensing or regulatory fees are for the period from January 1, 2011 to December 31, 2011, less any Federal and State taxes and licensing fees from the 2011 plan year that are to be deferred to the plan year 2012 calculation.

G. The medical loss ratio is calculated as the unrounded ratio of the numerator in C, adjusted for conditions in D and E, to the denominator in F.

H. The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in G and any applicable credibility adjustment.

I. The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard (individual, small group or large group).

J. (1) If the result of I is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium less Federal and State taxes and licensing or regulatory fees for 2011. The resulting amount is the rebate to be paid.

(2) If the result of I is zero or less, no rebate is to be paid.

Section 9. Medical Loss Ratio Rebate Calculation for Plan Year 2012

A. A rebate is not payable for any aggregation that is non-credible based on the sum of life years for plan years 2011 and 2012.

B. If, for any level of aggregation as defined in Section 5, 50% or more of the total earned premium for 2012 is attributable to policies newly issued in 2012 with less than 12 months of experience in 2012, the experience of these policies may be excluded from the medical loss ratio calculation for plan year 2012. The excluded experience shall be added to the experience used to calculate the medical loss ratio for plan year 2013. For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

C. The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality.

(1) Incurred claims are those with incurral dates from January 1, 2012 to December 31, 2012, plus any incurred claims deferred from the plan year 2011 calculation, less any claims incurred in 2012 that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, incurred claims are those with incurral dates from January 1, 2011 to December 31, 2012, less any claims incurred in 2012 that are to be deferred to the plan year 2013 calculation.

(2) Expenses to improve health care quality are those expenses for the period from January 1, 2012 to December 31, 2012, plus any expenses to improve health care quality deferred from the plan year 2011 calculation, less any expenses to improve health care quality from the 2012 plan year that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, expenses to improve health care quality are those for the period from January 1, 2011 to December 31, 2012, less any expenses to improve health care quality from the 2012 plan year that are to be deferred to the plan year 2013 calculation.

D. Numerator adjustment for insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2012, and shall apply to all groups as described in D(1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2012.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

E. Numerator adjustment for dual option insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides dual option insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2012, and shall apply to all groups as described in E(1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2012.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

F. The denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums less Federal and State taxes and licensing or regulatory fees.

(1) Earned premiums are for the period from January 1, 2012 to December 31, 2012, plus any earned premiums deferred from the plan year 2011 calculation, less any premiums earned in the 2012 plan year that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, earned premiums are for the period from January 1, 2011 to December 31, 2012, less any premiums earned in the 2012 plan year that are to be deferred to the plan year 2013 calculation.

(2) Federal and State taxes and licensing or regulatory fees are for the period from January 1, 2012 to December 31, 2012, plus any Federal and State taxes and licensing or regulatory fees deferred from the plan year 2011 calculation, less any Federal and State taxes and licensing or regulatory fees from the 2012 plan year that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, Federal and State taxes and licensing or regulatory fees are for the period from January 1, 2011 to December 31, 2012, less any Federal and State taxes and licensing or regulatory fees from the 2012 plan year that are to be deferred to the plan year 2013 calculation.

G. The medical loss ratio is calculated as the unrounded ratio of the numerator in C, adjusted for conditions in D and E, to the denominator in F.

H. The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in G and any applicable credibility adjustment.

I. The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard (individual, small group or large group).

J. (1) If the result of I is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium less Federal and State taxes and licensing or regulatory fees for the plan year. The resulting amount is the rebate to be paid.

(2) If the result of I is zero or less, no rebate is to be paid.

Section 10. Medical Loss Ratio Rebate Calculation for Plan Year 2013

A. A rebate is not payable for any aggregation that is non-credible based on the sum of life years for plan year 2011, plan year 2012 and plan year 2013.

B. If, for any level of aggregation as defined in Section 5, 50% or more of the total earned premium for 2013 is attributable to policies newly issued in 2013 with less than 12 months of experience in 2013, the experience of these policies may be excluded from the medical loss ratio calculation for plan year 2013. The excluded experience shall be added to the experience used to calculate the medical loss ratio

for plan year 2014. For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

C. The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality.

(1) Incurred claims are those with incurral dates from January 1, 2011 to December 31, 2013, less any claims incurred from January 1, 2013 to December 31, 2013 that are to be deferred to the plan year 2014 calculation.

(2) Expenses to improve health care quality are those expenses for the period from January 1, 2011 to December 31, 2013, less any expenses to improve quality from the 2013 plan year that are to be deferred to the plan year 2014 calculation.

D. Numerator adjustment for insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2013, and shall apply to all groups as described in D(1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2013.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

E. Numerator adjustment for dual option insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides dual option insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2013, and shall apply to all groups as described in E(1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2013.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

F. The denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums less Federal and State taxes and licensing or regulatory fees.

(1) Earned premiums are for the period from January 1, 2011 to December 31, 2013, less any premiums earned in 2013 that are to be deferred to the plan year 2014 calculation.

(2) Federal and State taxes and licensing or regulatory fees are for the period from January 1, 2011 to December 31, 2013, less any Federal and State taxes and licensing or regulatory fees from the 2013 plan year that are to be deferred to the plan year 2014 calculation.

G. The medical loss ratio is calculated as the unrounded ratio of the numerator in C, adjusted for conditions in D and E, to the denominator in F.

H. If both of the following conditions are met, no credibility adjustment will be applicable:

(1) Each of plan years 2011, 2012 and 2013 are partially credible based on the life years for each plan year, respectively, and;

(2) The medical loss ratio, before applying any credibility adjustments, for each of plan years 2011, 2012 and 2013 is less than the minimum medical loss ratio standard for each plan year, respectively.

(a) The plan year 2011 medical loss ratio is the quantity calculated in Section 8 G.

(b) The plan year 2012 medical loss ratio is calculated using the methodology given in Sections 9B, C, D, E, F, and G, with the exception that only experience from January 1, 2012 through December 31, 2012 is to enter into the calculation.

(c) The plan year 2013 medical loss ratio is the quantity calculated using the methodology given in Sections 10B, C, D, E, F, and G, with the exception that only experience from January 1, 2013 through December 31, 2013 is to enter into the calculation.

I. The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in G and any applicable credibility adjustment.

J. The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard (individual, small group or large group).

K. (1) If the result of J is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium less Federal and State taxes and licensing or regulatory fees for the plan year. The resulting amount is the rebate to be paid.

(2) If the result of J is zero or less, no rebate is to be paid.

Appendix A. Formats for Reporting Rebate Calculations

This appendix contains formats to report rebate calculations for the 2011, 2012, and 2013 plan years. Each report will require a separate supplemental information form for each experience year in the calculation.

"Line of Business" is the applicable aggregation as defined in Section 5.

"Minimum medical loss ratio" is the loss ratio as defined in Section 3B (15).

REBATE CALCULATION
FORM FOR PLAN YEAR 2011

Company_____ NAIC Company Code_____
For the State of_____ NAIC Group Code_____
Line of Business _____ Minimum Medical Loss Ratio_____
Address_____ Person Completing Exhibit _____
Title _____ Telephone Number_____

1 Line	2 Description	3 2011
1.	Life Years	
2.	Earned Premium	
3.	Federal and State Taxes and Licensing or Regulatory Fees	
4.	Expenses to Improve Heath Care Quality	
5.	Paid Claims	
6.	Unpaid Claim Reserve	
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds	
8.	Change in Contract Reserves	
9.	Contingent Benefit and Lawsuit Reserve	
10.	Incurred Medical Pool Incentives and Bonuses	
11.	Net Healthcare Receivables	
12.	Incurred Claims	
13.	Medical Loss Ratio	
14.	Credibility Adjustment Factor	
15.	Credibility Adjusted Medical Loss Ratio	
16.	Rebate	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

INSTRUCTIONS
REBATE CALCULATION FORM FOR PLAN YEAR 2011

Line 1: Life Years

Rebate Supplemental Form for experience year 2011

Line 2: Earned Premium

Rebate Supplemental Form for experience year 2011

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Rebate Supplemental Form for experience year 2011

Line 4: Expenses to Improve Health Care Quality

Rebate Supplemental Form for experience year 2011

Line 5: Paid Claims

Rebate Supplemental Form for experience year 2011

Line 6: Unpaid Claim Reserve

Rebate Supplemental Form for experience year 2011

Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds

Rebate Supplemental Form for experience year 2011

Line 8: Change in Contract Reserves

Rebate Supplemental Form for experience year 2011

Line 9: Contingent Benefit and Lawsuit Reserve

Rebate Supplemental Form for experience year 2011

Line 10: Incurred Medical Pool Incentives and Bonuses

Rebate Supplemental Form for experience year 2011

Line 11: Net Healthcare Receivables

Rebate Supplemental Form for experience year 2011

Line 12: Incurred Claims as of 3/31= Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 – Line 11

Line 13: Medical Loss Ratio = (Line 4 + Line 12) / (Line 2 – Line 3)

Line 14: Credibility Adjustment based on the number of life years in Line 1 and the methodology in Section7.

Line 15: Credibility Adjusted Medical Loss Ratio = Line 13 + Line 14

Line 16: If 2011 experience is non-credible as determined by Line 1, Rebate = 0, else,

If (Minimum Medical Loss Ratio - Line 15) is less than or equal to zero, Rebate = 0, else

Rebate = (Minimum Medical Loss Ratio - Line 15) · (Line 2 – Line 3),where (Minimum Medical Loss Ratio - Line 15) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.

REBATE CALCULATION FORM
FOR PLAN YEAR 2012

Company_____ NAIC Company Code_____
For the State of_____ NAIC Group Code_____
Line of Business _____ Minimum Medical Loss Ratio_____
Address_____ Person Completing Exhibit _____
Title _____ Telephone Number_____

1 Line	2 Description	3 2011	4 2012	5 Total
1.	Life Years			
2.	Earned Premium			
3.	Federal and State Taxes and Licensing or Regulatory Fees			
4.	Expenses to Improve Heath Care Quality			
5.	Paid Claims			
6.	Unpaid Claim Reserve			
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds			
8.	Change in Contract Reserves			
9.	Contingent Benefit and Lawsuit Reserve			
10.	Incurred Medical Pool Incentives and Bonuses			
11.	Net Healthcare Receivables			
12.	Incurred Claims			
13.	Medical Loss Ratio	XXX		
14.	Credibility Adjustment Factor	XXX		
15.	Credibility Adjusted Medical Loss Ratio	XXX	XXX	
16.	Rebate	XXX	XXX	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

INSTRUCTIONS
REBATE CALCULATION FORM FOR PLAN YEAR 2012

Line 1: Life Years

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 2: Earned Premium

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 4: Expenses to Improve Health Care Quality

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 5: Paid Claims

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 6: Unpaid Claim Reserve

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 8: Change in Contract Reserves

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 9: Contingent Benefit and Lawsuit Reserve

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 10: Incurred Medical Pool Incentives and Bonuses

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 11: Net Healthcare Receivables

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 12: Incurred Claims as of 3/31 = Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 – Line 11.

Line 13: Medical Loss Ratio = (Line 4 + Line 12) / (Line 2 – Line 3) for Column 4 and Column 5.

Line 14: Credibility Adjustment based on the number of life years in Line 1 for Column 4 and Column 5 and the methodology in Section 7.

Line 15 Column 5:

If Line 14 Column 4 is equal to zero
Credibility Adjusted Medical Loss Ratio = Line 13 Column 4

If Line 14 Column 4 is not equal to zero
Credibility Adjusted Medical Loss Ratio = Line 13 Column 5 + Line 14 Column 5

Line 16: If 2011 plus 2012 experience is non-credible as determined by Line 1 Column 5, Rebate = 0, else,

If (Minimum Medical Loss Ratio - Line 15) is less than or equal to zero, Rebate = 0, else

Rebate = (Minimum Medical Loss Ratio - Line 15 Column 5) · (Line 2 Column 4 – Line 3 Column 4), where (Minimum Medical Loss Ratio - Line 15 Column 5) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.

REBATE CALCULATION FORM
FOR PLAN YEAR 2013

Company_____ NAIC Company Code_____
For the State of_____ NAIC Group Code_____
Line of Business _____ Minimum Medical Loss Ratio_____
Address_____ Person Completing Exhibit _____
Title _____ Telephone Number_____

1 Line	2 Description	3 2011	4 2012	5 2013	6 Total
1.	Life Years				
2.	Earned Premium				
3.	Federal and State Taxes and Licensing or Regulatory Fees				
4.	Expenses to Improve Heath Care Quality				
5.	Paid Claims				
6.	Unpaid Claim Reserve				
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds				
8.	Change in Contract Reserves				
9.	Contingent Benefit and Lawsuit Reserve				
10.	Incurred Medical Pool Incentives and Bonuses				
11.	Net Healthcare Receivables				
12.	Incurred Claims				
13.	Medical Loss Ratio				
14.	Credibility Adjustment Factor	XXX	XXX	XXX	
15.	Credibility Adjusted Medical Loss Ratio	XXX	XXX	XXX	
16.	Rebate	XXX	XXX	XXX	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

INSTRUCTIONS
REBATE CALCULATION FORM FOR PLAN YEAR 2013

Line 1: Life Years

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 2: Earned Premiums

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 4: Expenses to Improve Health Care Quality

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 5: Paid Claims

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 6: Unpaid Claim Reserve

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 8: Change in Contract Reserves

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 9: Contingent Benefit and Lawsuit Reserve

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 10: Incurred Medical Pool Incentives and Bonuses

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 11: Net Healthcare Receivables

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 12: Incurred Claims as of 3/31 = Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 – Line 11

Line 13: Medical Loss Ratio = (Line 4 + Line 12) / (Line 2 – Line 3)

Line 14: Credibility Adjustment based on the number of life years in Line 1 for Column 6 and the methodology in Section 7.

Line 15: Credibility Adjusted Medical Loss Ratio = Line 13 + Line 14 for Column 6

Line 16: If the sum of 2011, 2012 and 2013 experience is non-credible as determined by Line 1 Column 6, Rebate = 0, else

If the experience of each of plan years 2011, 2012, and 2013 are partially credible as determined by Line 1 Columns 3, 4, and 5, respectively and the medical loss ratio for each of plan years 2011, 2012 and 2013 as determined by Line 13 Columns 3, 4, and 5, respectively is less than the Minimum Medical Loss Ratio for each plan year, respectively, Rebate = (Minimum Medical Loss Ratio - Line 13 Column 6) · (Line 2 Column 5 – Line 3 Column 5), rounded to the nearer dollar, else,

If (Minimum Medical Loss Ratio - Line 15 Column 6) is less than or equal to zero, Rebate = 0, else

Rebate = (Minimum Medical Loss Ratio - Line 15 Column 6) · (Line 2 Column 5 – Line 3 Column 5), where (Minimum Medical Loss Ratio - Line 15 Column 6) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.

REBATE CALCULATION SUPPLEMENTAL FORM

Plan Year ____
Experience Year ____

Company_____ NAIC Company Code_____
For the State of_____ NAIC Group Code_____
Line of Business _____
Address_____ Person Completing Exhibit _____
Title_____ Telephone Number_____

1 Line	2 Description	3 12/31	4 Deferred	5 Added	6 Total
1.	Life Years				
2.	Earned Premium				
3.	Federal and State Taxes and Licensing or Regulatory Fees				
4.	Expenses to Improve Heath Care Quality				
5.	Paid Claims				
6.	Unpaid Claim Reserve				
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds				
8.	Change in Contract Reserves				
9.	Contingent Benefit and Lawsuit Reserve				
10.	Incurred Medical Pool Incentives and Bonuses				
11.	Net Healthcare Receivables				
12.	Incurred Claims				

INSTRUCTIONS
REBATE CALCULATION SUPPLEMENTAL FORM

Column 3 is data from the Supplemental Health Care Exhibit in the NAIC Annual Statement for the experience year.

Column 4 is data for policies newly issued in the experience year with less than 12 months of experience in that year that are excluded from the medical loss ratio calculation for the plan year of issue and will be added back in the next plan year. Column 5 is data for policies newly issued in a prior experience year with less than 12 months of experience in that year that were excluded from the medical loss ratio calculation for a prior plan year and are added back in this plan year. See Sections 8B, 9B, and 10B for additional details.

Note that quantities in Lines 2 through 9 should be allocated to represent only the experience associated with the deferred business using reasonable methods.

Line 1: Life Years

Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1 Other Indicators, Column(s) for applicable line of business - Line 4 divided by 12 and rounded to zero decimal places.

Line 2: Earned Premium

Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 2, Column(s) for applicable line of business – Line 1.8 – Line 1.7, plus Part 1, Column(s) for applicable line of business – Line 1.2 + Line 1.3, plus or minus any portions of premium associated with group conversion privileges between Group and Individual lines of business in its Annual Statement accounting, plus or minus any incurred experience rating refunds.

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 1.5 + Line 1.6 + Line 1.7

Line 4: Expenses to Improve Health Care Quality

Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 6.3

Line 5: Paid Claims

Amounts paid on claims incurred in the experience year as of March 31 of the year following the plan year, plus or minus any portions of premium associated with group conversion privileges between Group and Individual lines of business in its Annual Statement accounting, plus Deductible Fraud and Abuse Detection/Recovery Expenses from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 4, minus any state stop loss, market stabilization and claim/census based assessments from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 2.4, plus or

minus any adjustment from paragraphs D(4) and/or E(4) in Section 8, Section 9 or Section 10.

Line 6: Unpaid Claim Reserve

The reserve for amounts unpaid on claims incurred in the experience year as of March 31 of the year following the plan year.

Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds

Experience rating refunds incurred in the experience year and paid through March 31 of the year following the plan year, plus the estimate as of March 31 of the year following the plan year for any reserves experience rating refunds incurred in the experience year, plus any state premium refunds incurred in the experience year. For the 2012 plan year, include any rebate paid pursuant to Section 8 for plan year 2011 if the 2012 experience is not fully credible on its own and 2011 experience enters into the plan year 2012 calculation. For the 2013 plan year, include any rebate paid pursuant to Section 8 for plan year 2011, plus any rebate paid pursuant to Section 9 for plan year 2012.

Line 8: Change in contract reserves

Change in contract reserves from December 31 of the year prior to the experience year to December 31 of the plan year after eliminating the effect of any valuation basis changes.

Line 9: Contingent Benefit and Lawsuit Reserve

Contingent Benefit and Lawsuit Reserve for claims incurred in the experience year as of March 31 of the year following plan year.

Line 10: Incurred Medical Pool Incentives and Bonuses

Medical Pool Incentives and Bonuses incurred in the experience year as of March 31 of the year following the plan year.

Line 11: Net Healthcare Receivables

Net Healthcare Receivables incurred in the experience year as of March 31 of the year following the plan year.

Line 12: Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 – Line 11

Appendix B. Credibility Tables

Table 1	
Base Credibility Additive Adjustment Factors	
Life Years	**Additive Adjustment**
< 1,000	No Credibility
1,000	8.3%
2,500	5.2%
5,000	3.7%
10,000	2.6%
25,000	1.6%
50,000	1.2%
75,000	0.0%

Table 2	
Plan Cost-Sharing Adjustment Factors by Deductible	
Deductible Range	**Adjustment Factor**
< $2,500	1.000
$2,500	1.164
$5,000	1.402
>= $10,000	1.736

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions

Federal and State Taxes and Licensing or Regulatory Fees:

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1:

Line 1.5 – Federal Taxes and Federal Assessments

Refer to SSAP 10R for "current income taxes incurred."

Include: All federal taxes and assessments allocated to health insurance coverage reported under Section 2718 of the Public Health Service Act.

Exclude: Federal income taxes on investment income and capital gains.

Line 1.6 – State Insurance, Premium and Other Taxes and Assessments

Include: Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State.

Guaranty fund assessments

Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by states.

Advertising required by law, regulation or ruling, except advertising associated with investments.

State income, excise, and business taxes other than premium taxes.

State premium taxes plus state taxes based on policy reserves, if in lieu of premium taxes.

EITHER*:

a. Payments to a state, by not-for-profit health plans, of premium tax exemption values in lieu of state premium taxes limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group;

b. Payments by not-for-profit health plans for community benefit expenditures** limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group. These payments must be state-based requirements to qualify for inclusion in this line item;

OR

c. Payments made by (federal income) tax exempt health plans for community benefit expenditures** limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group. (NOTE: If the instruction for Line 1.5 above excludes federal income taxes, then tax exempt health plans may NOT include community benefit expenditures in this line.)

Exclude: State sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.

Any portion of commissions or allowances on reinsurance assumed that represents specific reimbursement of premium taxes.

Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

* These expenditures may not be double counted between this category; the federal or state assessments for similar purposes included in Lines 1.5, 1.6, or 2.4; or the Quality Improvement expenses reported in Line 6.1.

** Community benefit expenditures are for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes activities that:

- Are available broadly to the public and serve low-income consumers;
- Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (e.g., longer wait times or increased travel distances);
- Address federal, state, or local public health priorities such as advancing health care knowledge through education or research that benefits the public;
- Leverage or enhance public health department activities such as childhood immunization efforts; or
- Otherwise would become the responsibility of government or another tax-exempt organization.

Line 1.7 – Regulatory Authority Licenses and Fees

Include: Statutory assessments to defray operating expenses of any state insurance department.

Examination fees in lieu of premium taxes as specified by state law.

Exclude: Fines and penalties of regulatory authorities.

Fees for examinations by state departments other than as referenced above.

Expenses to Improve Health Care Quality:

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3:

Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self insured plans. Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. They should not be designed primarily to control or contain cost, although they may have cost reducing or cost neutral benefits as long as the primary focus is to improve quality. Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates;
- Increase wellness and promote health activities; or
- Enhance the use of health care data to improve quality, transparency, and outcomes.

NOTE: Expenses which otherwise meet the definitions for QI but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.

PARTS 3A and 3B

COLUMNS:

Column 1 – Improve Health Outcomes

Expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined above. This category can include costs for associated activities such as:

- Effective case management, Care coordination, and Chronic Disease Management, including:
  - Patient centered intervention such as:
    - Making/verifying appointments,
    - Medication and care compliance initiatives,
    - Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center),
    - Programs to support shared decision making with patients, their families and the patient's representatives; and
    - Reminding insured of physician appointment, lab tests or other appropriate contact with specific providers.
  - Incorporating feedback from the insured to effectively monitor compliance;
  - Providing coaching or other support to encourage compliance with evidence based medicine;
  - Activities to identify and encourage evidence based medicine;
  - Use of the medical homes model as defined for purposes of section 3602 of PPACA);
  - Activities to prevent avoidable hospital admissions;
  - Education and participation in self management programs;
  - Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance; and
  - Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities included in Columns 1-5;
- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;
- Quality reporting and documentation of care in non-electronic format; and
- Health information technology expenses to support these activities (report in Column 5 - see instructions) including:
  - Data extraction, analysis and transmission in support of the activities described above; and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; and

Column 2 – Activities to Prevent Hospital Readmission

Expenses for implementing activities to prevent hospital readmissions as defined above, including:

- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
- Personalized post discharge counseling by an appropriate health care professional;
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including:
    - Data extraction, analysis and transmission in support of the activities described above; and
    - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; and

Column 3 – Improve Patient Safety and Reduce Medical Errors

Expenses for implementing activities to improve patient safety and reduce medical errors as defined above through:

- The appropriate identification and use of best clinical practices to avoid harm;
- Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns;
- Activities to lower risk of facility acquired infections;
- Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions;
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and
- Health information technology expenses to support these activities (report in Column 5 – See instructions), including:
    - Data extraction, analysis and transmission in support of the activities described above; and
    - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; or

Column 4 – Wellness & Health Promotion Activities

Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or web-based interactions or other forms of communication), including:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
- Public health education campaigns that are performed in conjunction with state or local health departments;
- Actual rewards/incentives/bonuses/reductions in copays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI with the following restrictions:
    - Only allowed for small and large employer groups, not individual business; and the expense amount is limited to the same percentage as the HIPAA incentive amount limit;
- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); and
- Health information technology expenses to support these activities (Report in Column 5 – See instructions).

Column 5 – HIT Expenses for Health Care Quality Improvements

The PPACA also contemplates "Health Information Technology" as a function that may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, consistent with Medicare/Medicaid meaningful use requirements, in the following ways;

1. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law;

2. Advancing the ability of enrollees, providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history;

3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

4. Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of indentifying or treating specific conditions or controlling the spread of disease; or

5. Provision of electronic health records and patient portals.

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements.

Expense Allocation

Supplemental Filing: A single (not state-by-state), separate, regulator only supplemental filing must be made by the insurer to provide a description of the method utilized to allocate QI expenses to each State and to each line and column on Part 3. Additionally, companies reporting QI expenses in Part 3, Columns 1 through 5 must include a detailed description of such expense elements, including how the specific expenses meet the definitions above. The definitions established in the Supplemental Health Care Exhibit apply to this supplemental filing as well. For a new initiative that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an "X" in the "New" column of the supplement and include in the description the expected timeframe for the activity to accomplish the objective, verifiable results. Expenses for prospective Utilization Review and the costs of reward or bonuses associated with wellness and health promotion that are included in QI should include an "E" in the "New" column. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes.

Notes: a. *Healthcare Professional Hotlines*: Expenses for healthcare professional hotlines should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities.

b. *Prospective Utilization Review*: Expenses for prospective Utilization Review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

The following items are broadly excluded as not meeting the definitions above:

- All retrospective and concurrent Utilization Review;
- Fraud Prevention activities (all are reported as cost containment, but Part 1, Line 4 includes MLR recognition of fraud detection/recovery expenses up to the amount recovered that reduces incurred claims);
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- Provider Credentialing;
- Marketing expenses;
- Any accreditation fees that are not directly related to activities included in Columns 1-5;
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- Any function or activity not expressly included in Columns 1 through 5.

Note: The NAIC will review requests to include expenses for broadly excluded activities and activities not described under Columns 1 through 5 above. Upon an adequate showing that the activity's costs support the definitions and purposes therein, or otherwise support monitoring, measuring, or reporting health care quality improvement, the NAIC may recommend that the HHS Secretary certify those expenses as Quality Improvement.

Direct Claims Incurred

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2:

Line 2 – Direct Claims Incurred:

Hospital/Medical Benefits

Include: Expenses for physician services provided under contractual arrangement to the reporting entity.

Salaries, including fringe benefits, paid to physicians for delivery of medical services. Capitation payments by the reporting entity to physicians for delivery of medical services to reporting entity subscribers.

Fees paid by the reporting entity to physicians on a fee-for-service basis for delivery of medical services to reporting entity subscribers. This includes capitated referrals.

Inpatient hospital costs of routine and ancillary services for reporting entity members while confined to an acute care hospital.

Charges for non-reporting entity physician services provided in a hospital are included in this line item only if included as an undefined portion of charges by a hospital to the reporting entity. (If separately itemized or billed, physician charges should be included in outside referrals, below).

The cost of utilizing skilled nursing and intermediate care facilities.

Routine hospital service includes regular room and board (including intensive care units, coronary care units, and other special inpatient hospital units), dietary and nursing services, medical surgical supplies, medical social services, and the use of certain equipment and facilities for which the provider does not customarily make a separate charge.

Ancillary services may also include laboratory, radiology, drugs, delivery room, physical therapy services, other special items and services for which charges are customarily made in addition to a routine service charge.

Skilled nursing facilities are primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care or rehabilitation service.

Intermediate care facilities are for individuals who do not require the degree of care and treatment that a hospital or skilled nursing-care facility provides, but that do require care and services above the level of room and board.

Other Professional Services

Include: Expenses for other professional providers under contractual arrangement to the reporting entity.

Salaries, as well as fringe benefits, paid by the reporting entity to non-physician providers licensed, accredited or certified to perform specified clinical health services, consistent with state law, engaged in the delivery of medical services to reporting entity enrollees. Capitation payments by the reporting entity to such clinical service.

Compensation to personnel engaged in activities in direct support of the provision of medical services.

Exclude: Professional services not meeting this definition. Report these services as administrative expenses. For example, exclude compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel, and medical record clerks.

Outside Referrals

Include: Expenses for providers not under arrangement with the reporting entity to provide services, such as consultations, or out-of-network providers.

Emergency Room and Out-of-Area

Include: Expenses for other health delivery services including emergency room costs incurred by members for which the reporting entity is responsible and out-of-area service costs for emergency physician and hospital.

In the event a member is admitted to the health care facility immediately after seeking emergency room service, emergency service expenses are reported in this line, the expenses after admission are reported in the hospital/medical line, provided the member is seeking services in the service area. Out-of-area expenses incurred, whether emergency or hospital, are reported in this line.

Aggregate Write-ins for Other Hospital and Medical

Incurred Medical Pool Incentives and Bonuses

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2:

Line 2.8 – Incurred Medical Incentive Pools and Bonuses

Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings with contracted providers.

Net Healthcare Receivables

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2:

Line 2.9 – Net Healthcare Receivables

Report the change between prior year healthcare receivables and current year healthcare receivables. The amounts on this line are the gross healthcare receivable assets, not just the admitted portion. This amount should not include those healthcare receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2010 Fall National Meeting (adopted)

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Exhibit I

Image A (AmeriHealth HMO website with AmeriHealth Mercy affiliation):

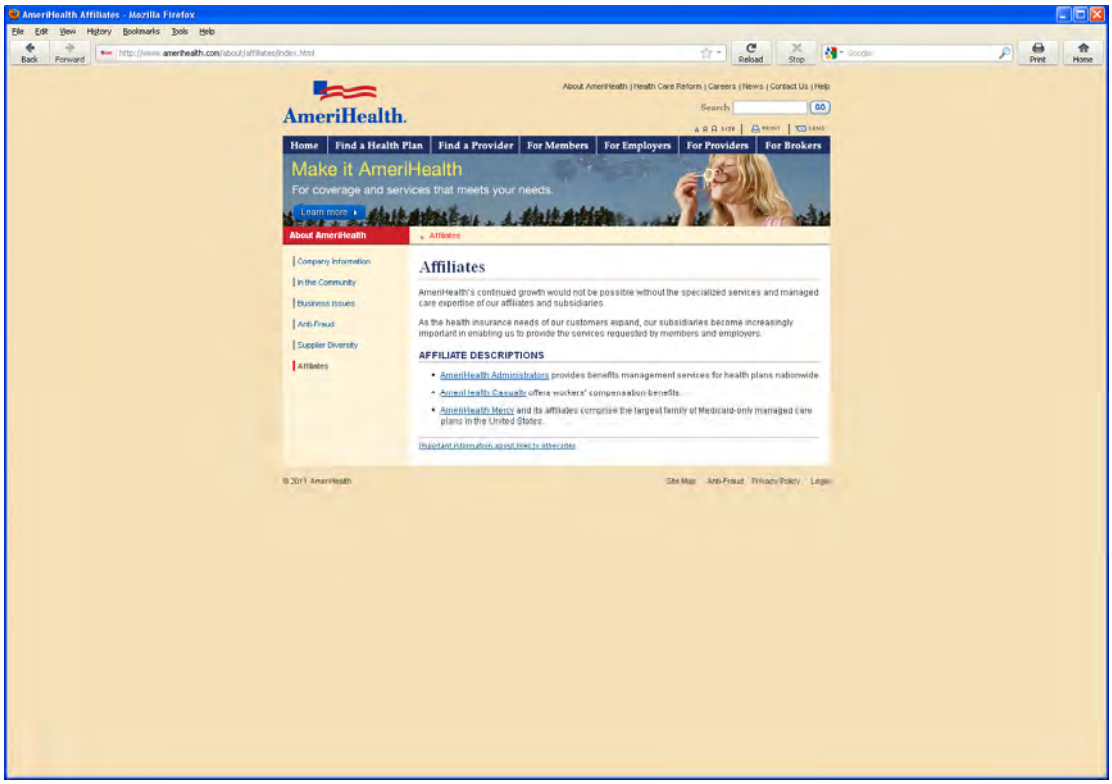

Image B (AmeriHealth Mercy website with Passport Heath Plan and PerformRx relationships):

Exhibit I

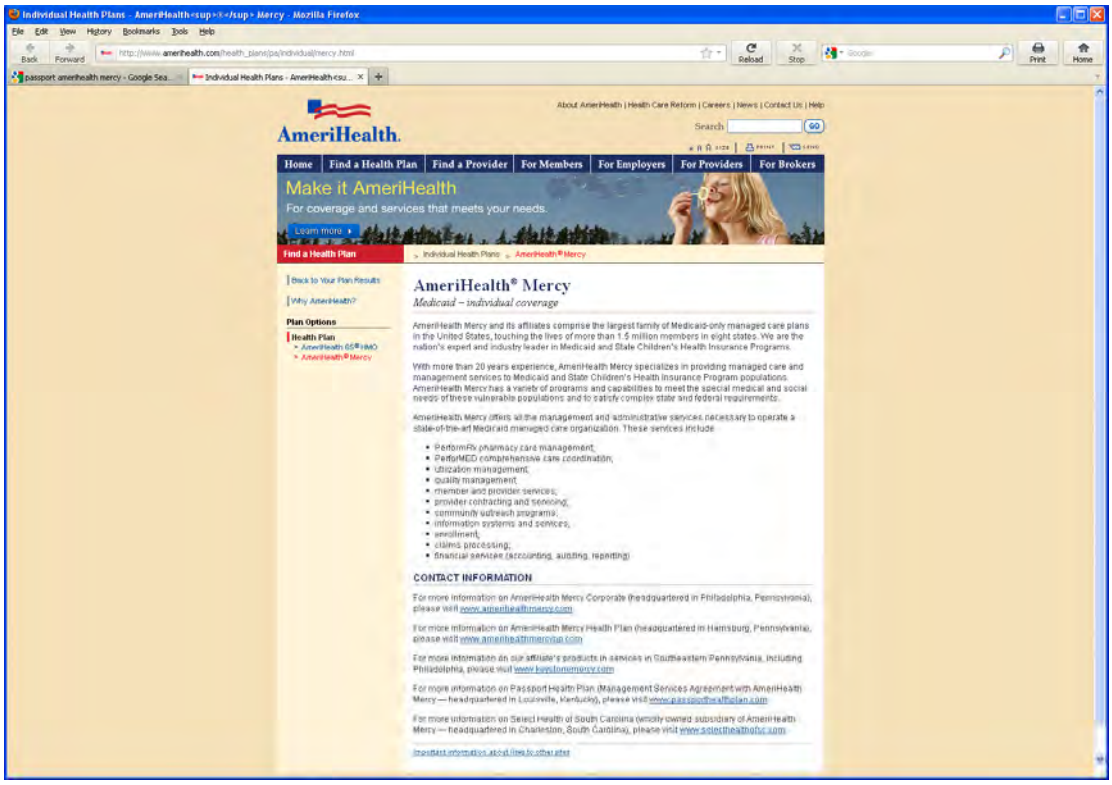

Image C (AmeriHealth Mercy office photograph with PerformRx relationship):

Image D (AmeriHealth Mercy website with PerformRx relationship):

Exhibit I

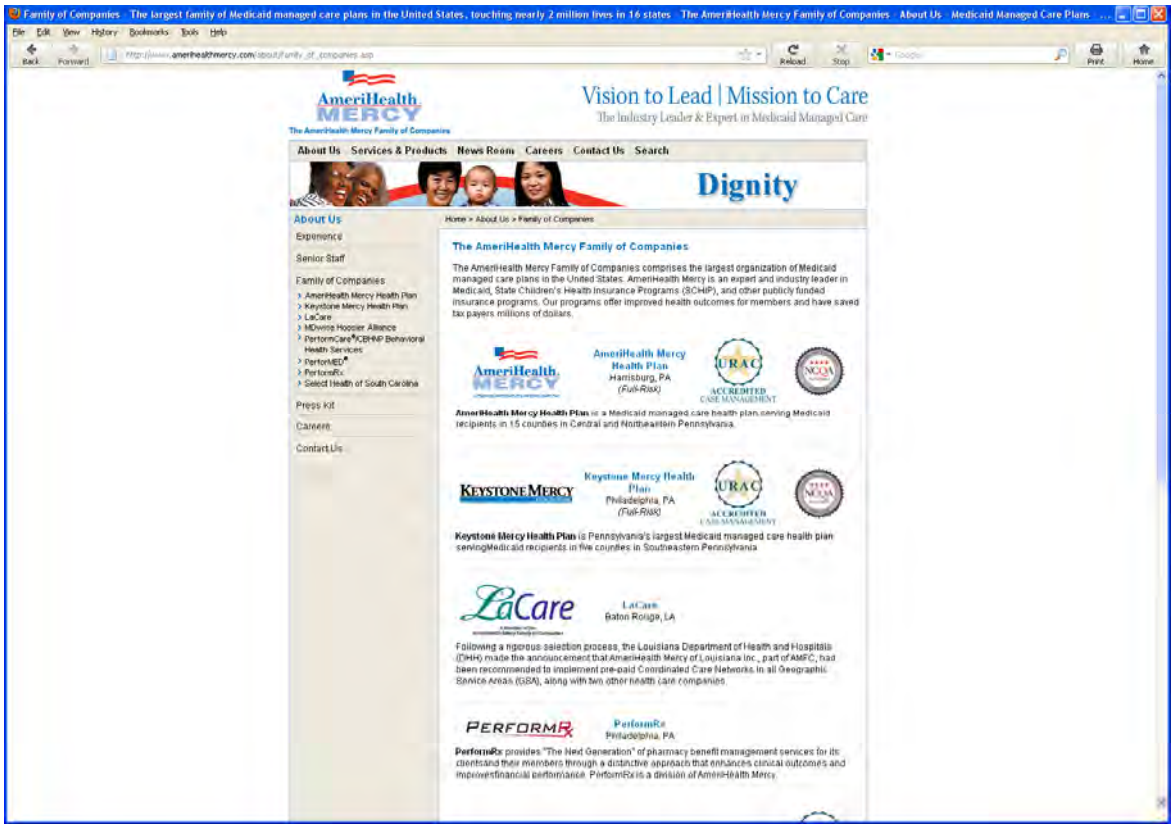

Image E (Independence Blue Cross Blue Shield website with AmeriHealth relationship):

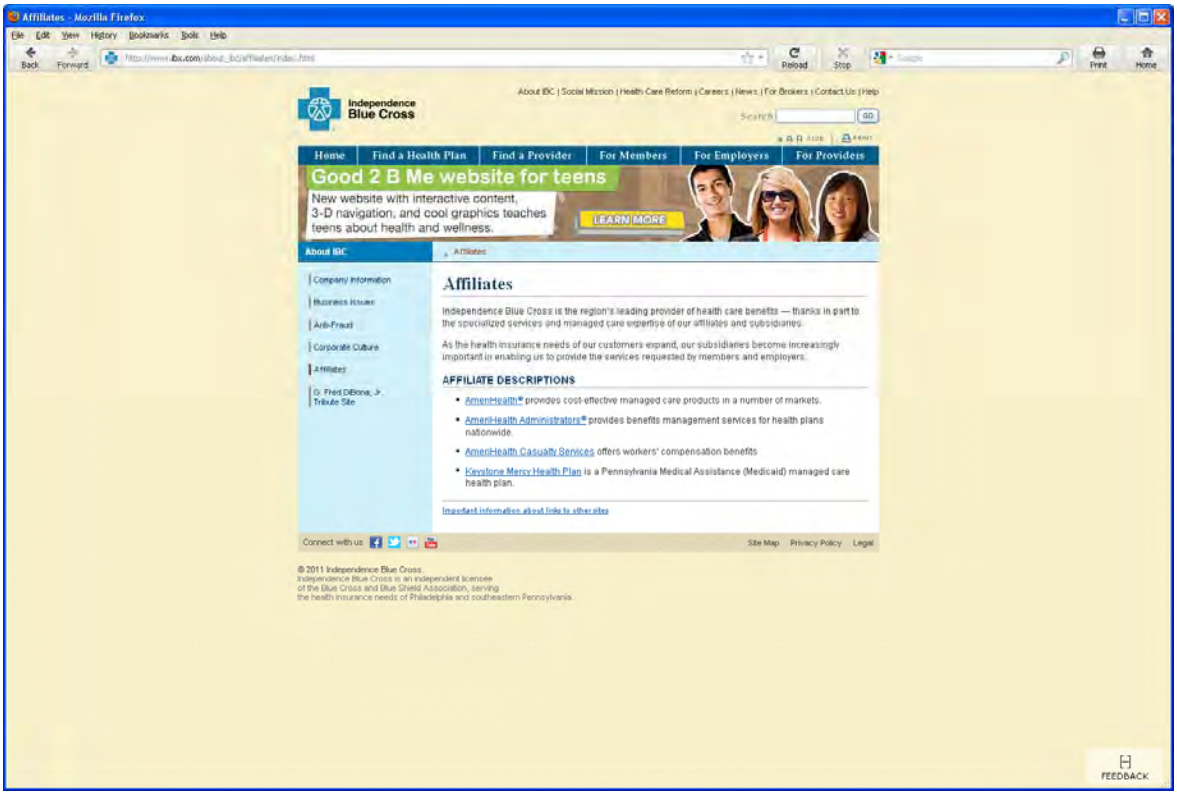

Exhibit I

Image F (Kentucky Secretary of State Listing – AmeriHealth HMO):

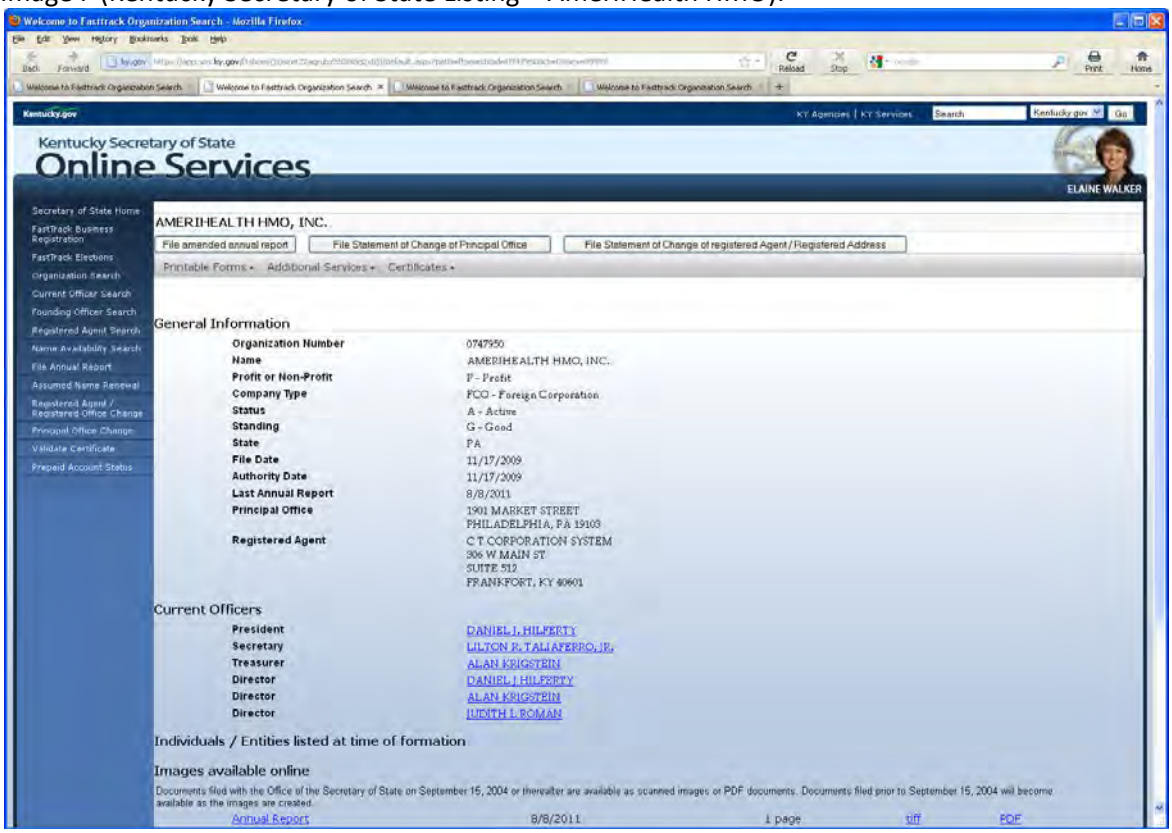

Image G (Kentucky Secretary of State Listing – AmeriHealth Mercy):

Exhibit I

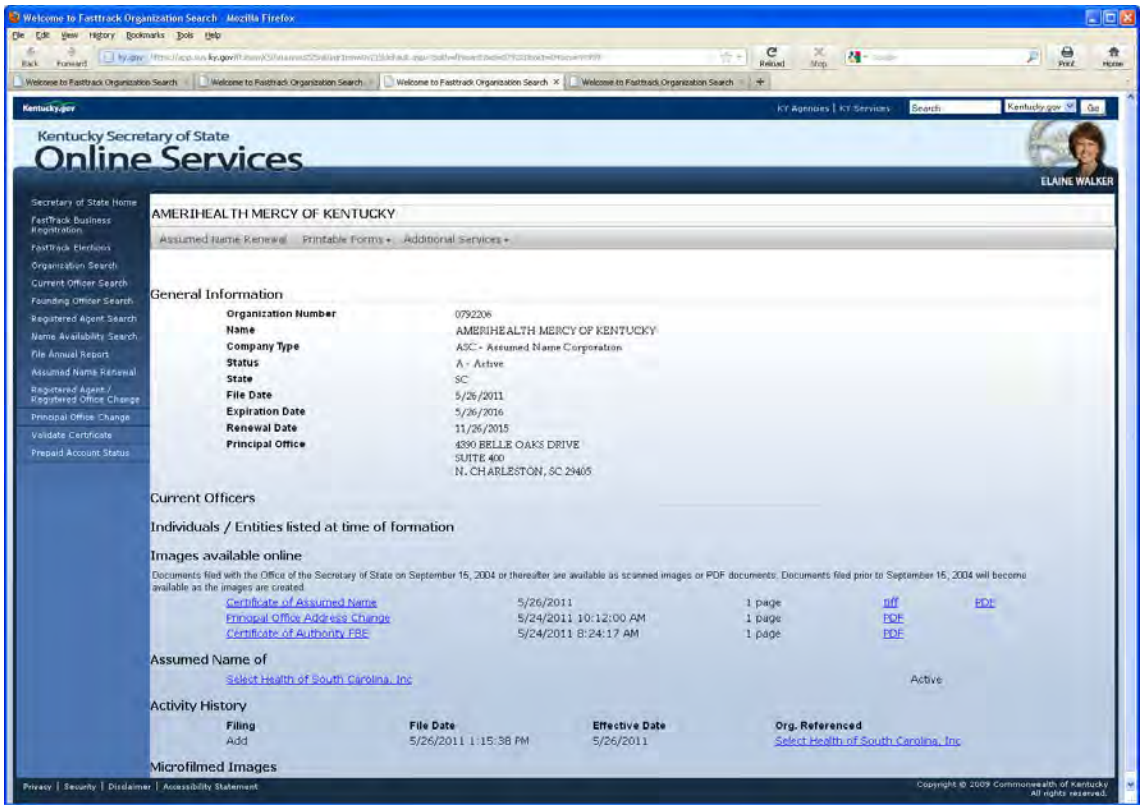

Image H (Kentucky Secretary of State Listing – Block Vision, Inc.):

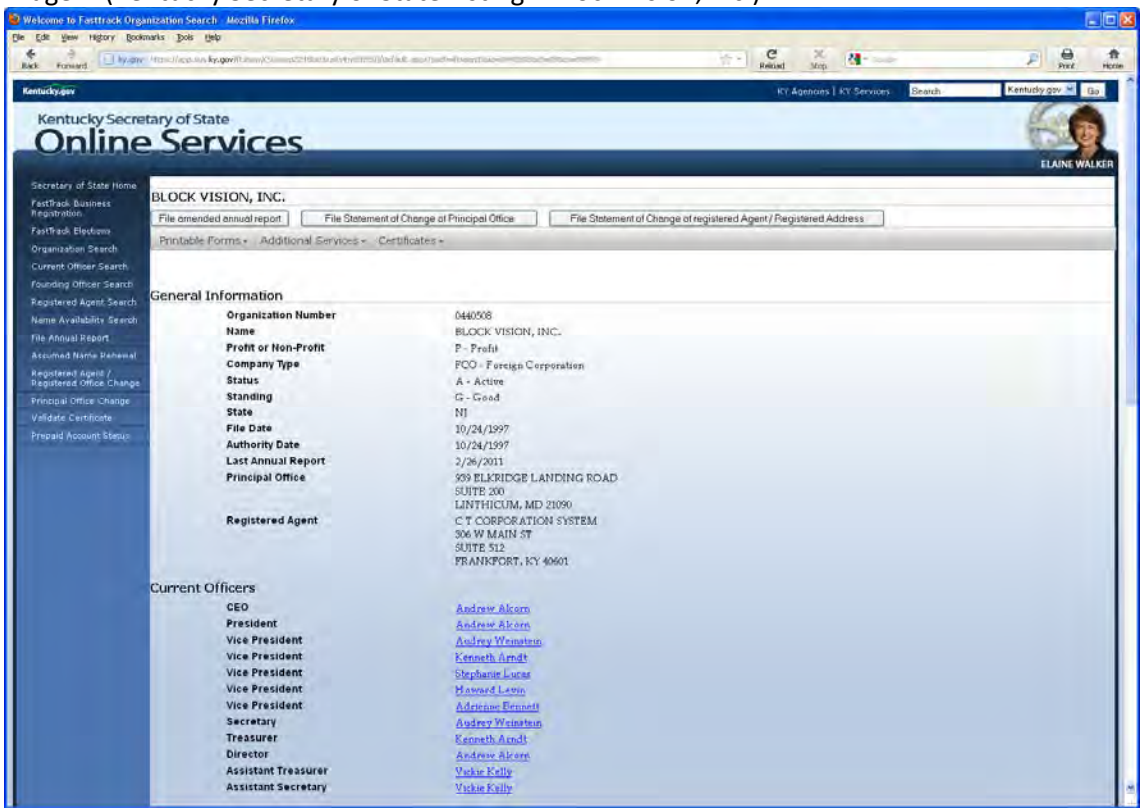

Image I (Kentucky Secretary of State Listing – DentaQuest of Kentucky):

Exhibit I

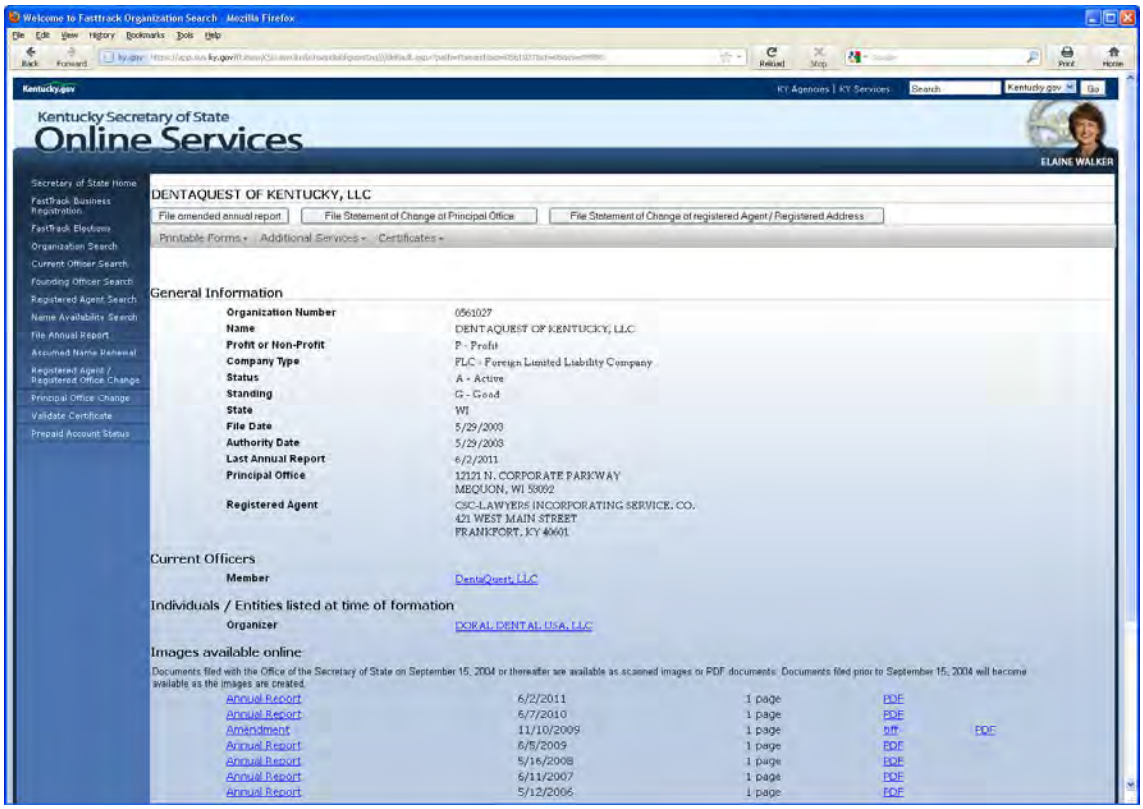

Image J (Kentucky Secretary of State Listing – Healthcare Options Incorporated):

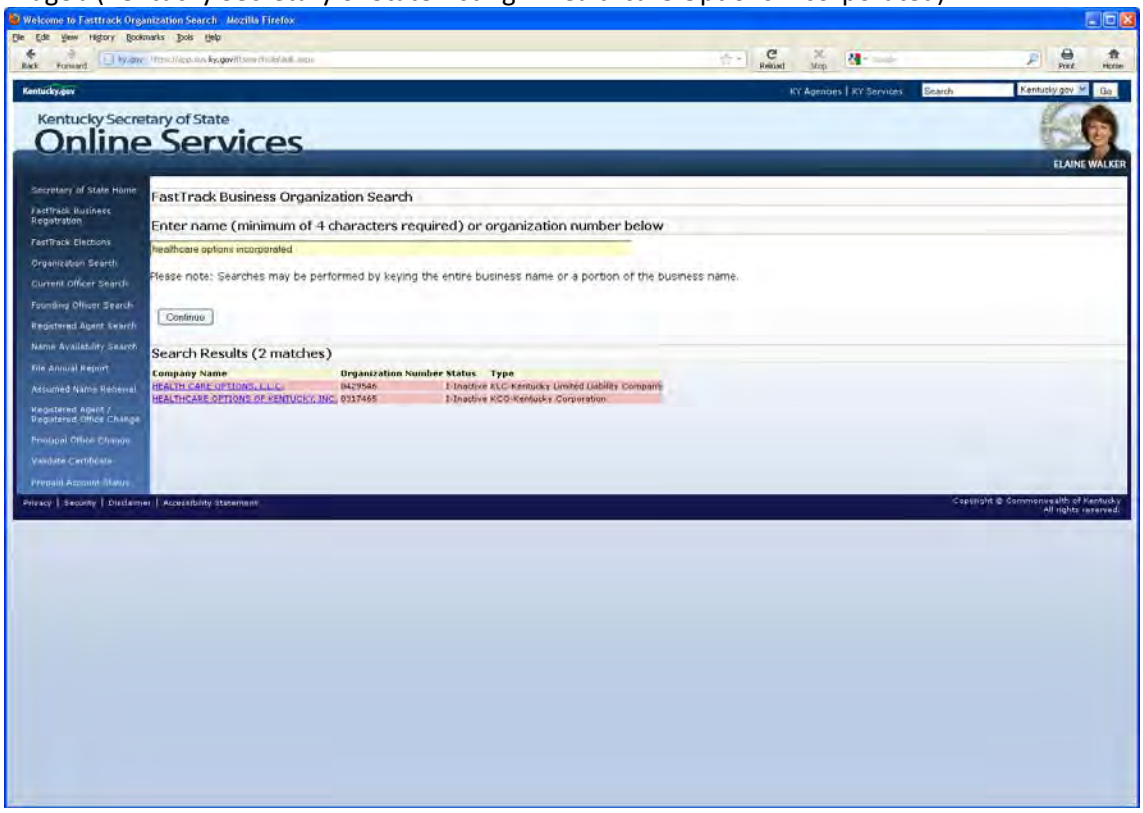

Image K (Kentucky Secretary of State Listing – ikaSystems Corporation):

Exhibit I

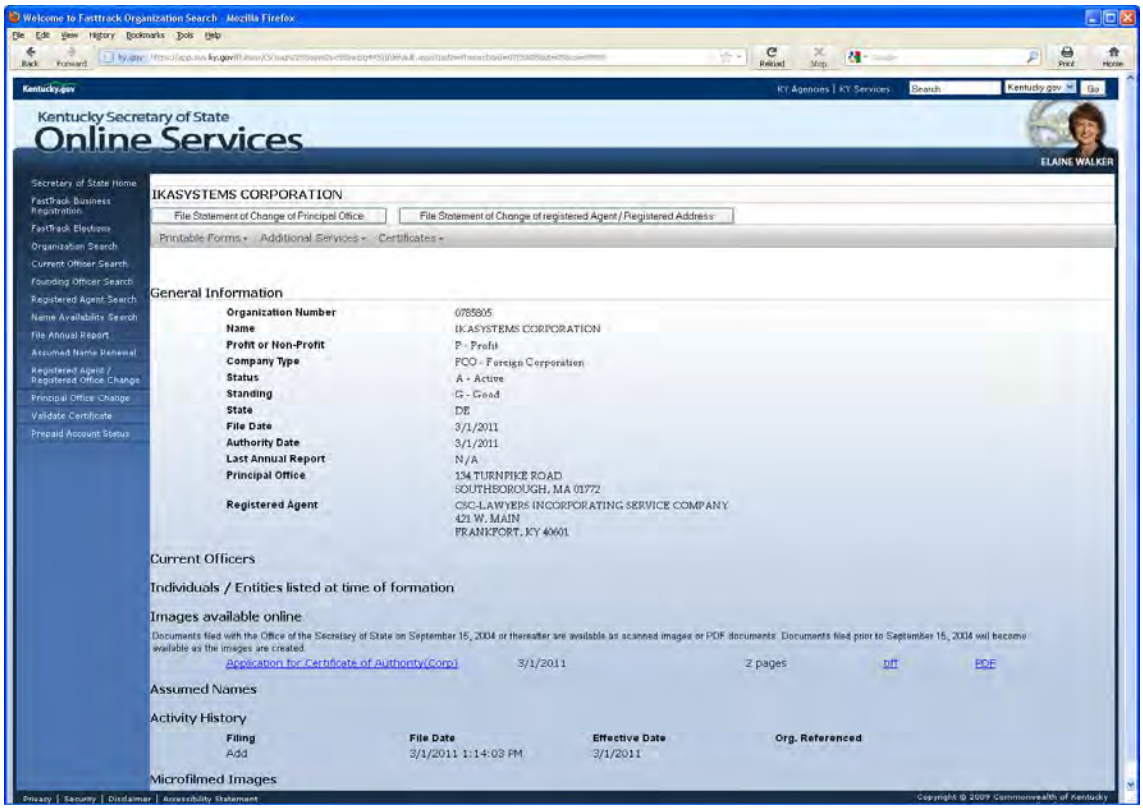

Image L (Kentucky Secretary of State Listing – MCNA):

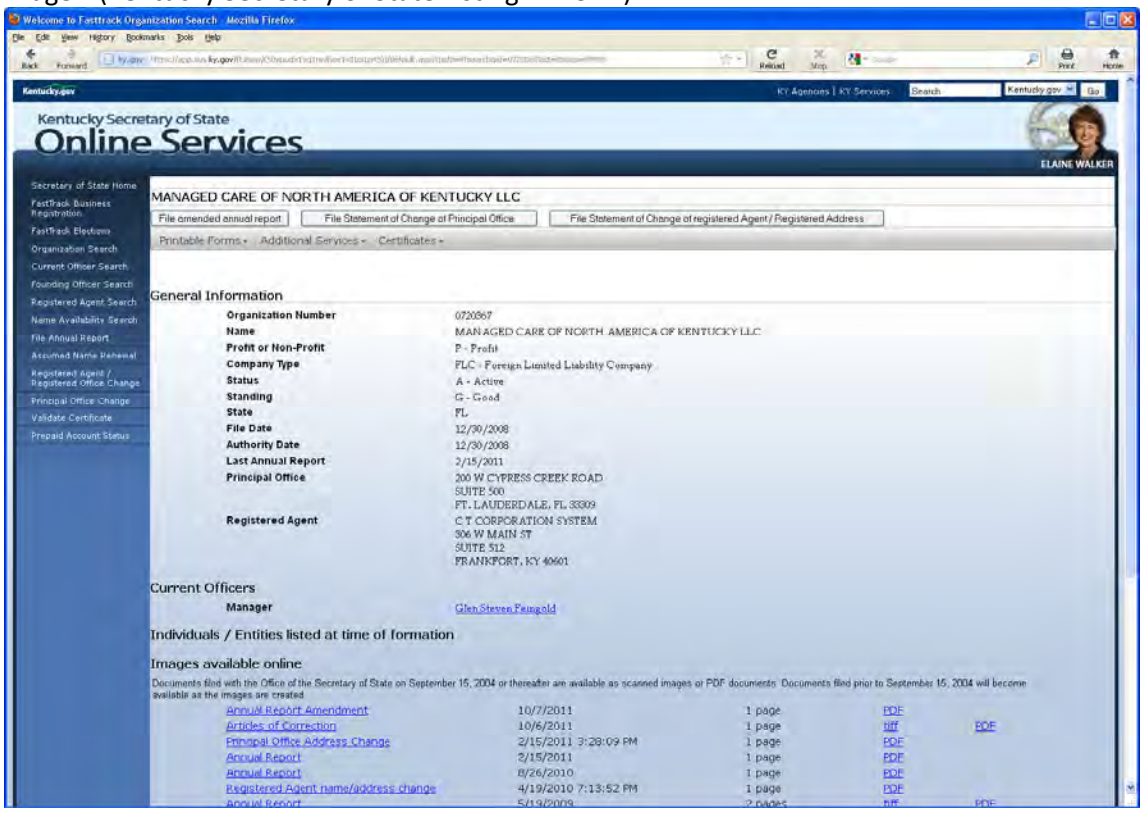

Image M (Kentucky Secretary of State Listing – PerformRx):

Exhibit I

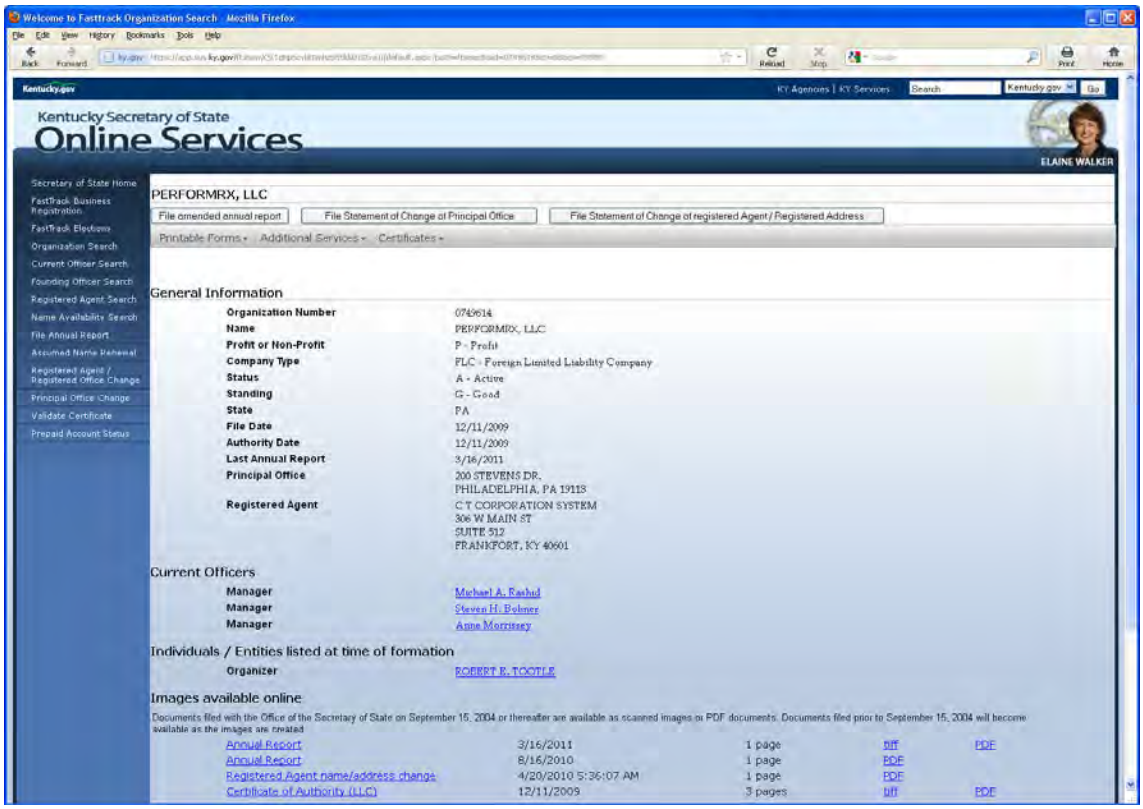

Image N (Kentucky Secretary of State Listing – SironaHealth, Inc. [1 of 2]):

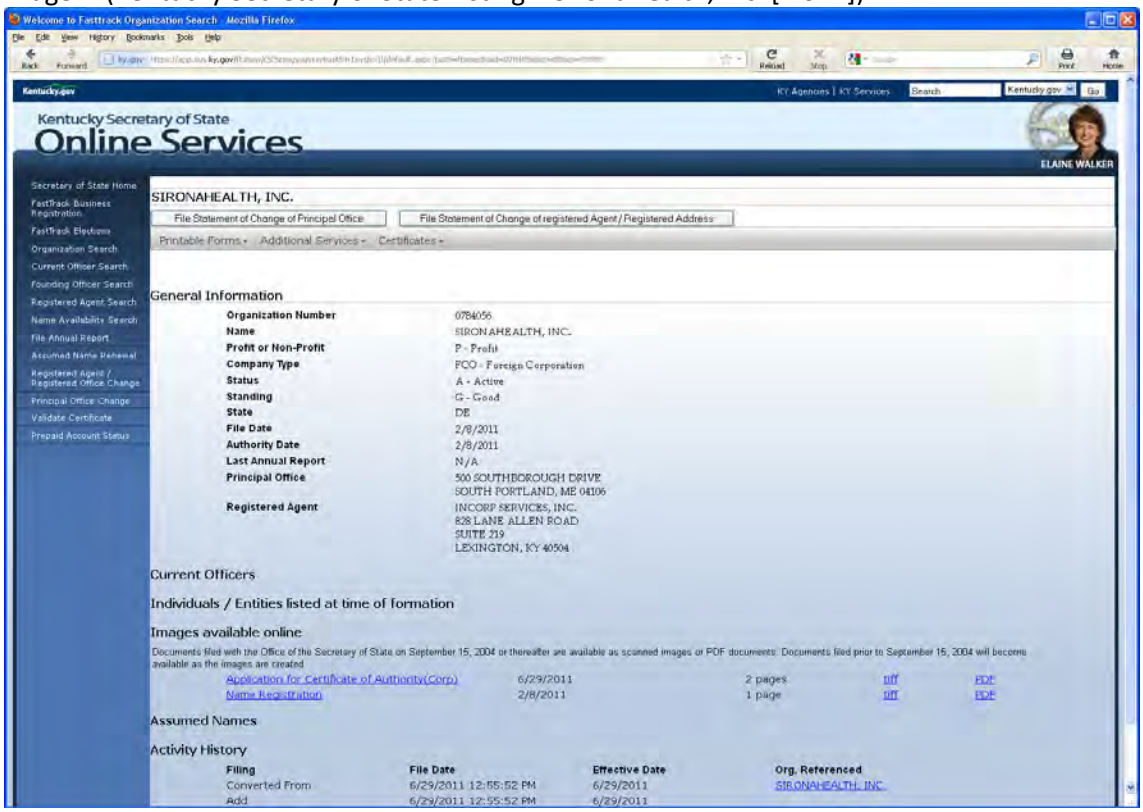

Image O (Kentucky Secretary of State Listing – SironaHealth, Inc. [2 of 2]):

Exhibit I

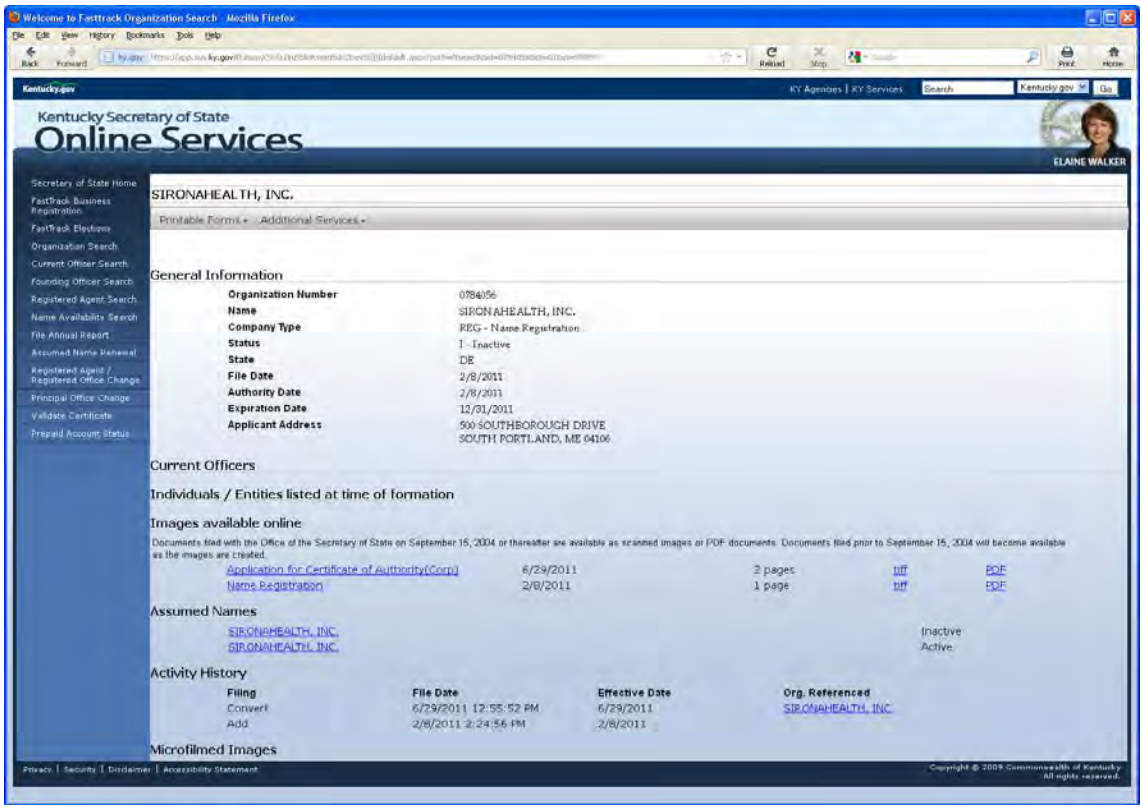

Image P (Kentucky Secretary of State Listing – University Physicians Associates):