CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST BACKGROUND

Background for this checklist:
This checklist is used to assess the interfaces between the MMIS and the MCO and reports produced by the MMIS using MCO encounter and capitation payment data.

1. Managed Care Organization (MCO) encompasses different forms of risk bearing, comprehensive health care service organizations including Health Maintenance Organizations (HMO), State-regulated MCO, county or locally operated health care organizations, and other models. The MCO assumes risk to deliver a comprehensive and defined benefit package to enrolled members for a fixed monthly premium payment.
2. Most States have at least one form of MCO. Some States have created a number of different models. This checklist should cover all types of MCO.
3. The checklist assumes that the member enrollment function is covered in the separate Managed Care Enrollment Checklist. Direct communications between the MMIS and MCO information system for the purposes of exchanging member enrollment information are included within the Managed Care Enrollment Checklist.
4. The checklist covers provider enrollment into the MCO, capitation payment, encounter data collection, and Medicaid review activities supported by MCO data processed by the MMIS. It does not cover activities performed by the MCO itself.
5. The Medicaid agency may use other resources external to the MMIS for managing the MCO contractors. The requirements in this checklist assume that the MMIS is the source of data collection and analysis used to manage the MCOs.

Sources for the criteria in this checklist are as follows:
CFR – Code of Federal Regulations, available from http://www.access.gpo.gov/uscode/title42/title42.html
IBP – Industry Best Practice. Items are selected from RFPs for MMISs developed by states and approved by CMS.
HIPAA – HIPAA act, available from
http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

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BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
MC1	Support assessment of members' access to services.	
MC2	Make accurate payment to MCO for managed care services provided to enrolled members.	
MC3	Receive, process, and store MCO encounter records for use by the Medicaid agency in managing MCO performance.	
MC4	Provide information to support assessing quality and cost of care provided to enrollees.	
MC5	Identify services covered under capitation premiums and block duplicate fee-for-service payments and supplemental payments to providers.	
MC6	Collect and report on financial data related to Medicaid managed care programs	
MC7	Collect data and provide reporting to support MCO contractor monitoring (optional).	
MC8	Support specific functions, as applicable, related to the administration of Section 1115 Waivers.	
MCSS1	*Add State-specific business objectives for the Managed Care Organization Interfaces Checklist here.*	

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MC1 – SUPPORT ASSESSMENT OF MEMBER ACCESS TO SERVICES					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC1.1	Captures information on contracted MCOs, including geographic locations, capitation rates, and organization type.	IBP			
MC1.2	Captures information identifying contracted providers within MCO network, including PCPs.	CFR			
MC1.3	Captures information identifying physicians who have agreed to provide gatekeeper services, number of Beneficiaries assigned, and capacity to accept additional patients.	IBP			
MC1.4	Accepts and processes update information as changes are reported.	IBP			
MC1.5	Captures termination information when an MCO contract is cancelled.	IBP			
MC1.6	Removes and end-dates PCP status from MCO (optional if States require MCO to identify PCPs).	IBP			
MC1.7	Provides information to support assessment of adequacy of provider network. This includes identifying and collecting data on the number and types of providers and provider locations.	CFR			
MC1.8	Provides information to support review of new enrollments and to prohibit affiliations with individuals debarred by Federal Agencies.	CFR			
MC1SS.1	*Add State-specific criteria for this objective here.*				

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MC2 – MAKE ACCURATE PAYMENTS TO MCOs					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC2.1	Calculates per-member per-month (PMPM) capitation payment based on State-defined rate factors such as age, sex, category of eligibility, health status, geographic location, and other.	IBP			
MC2.2	Computes capitation payment for the actual number of days of eligibility in a month (i.e., enrollee may not be enrolled for a full month).	IBP			
MC2.3	Identifies individuals/enrollees who have terminated enrollment, disenrolled, or are deceased, and excludes those individuals from the monthly MCO capitation payment.	IBP			
MC2.4	Generates regular capitation payments to MCOs, at least on a monthly basis in compliance with HIPAA-standard X12 820 Premium Payment transaction where applicable.	IBP			
MC2.5	Adjusts capitation payment based on reconciliation of errors or corrections (e.g., retroactive adjustments to a particular capitation payment based on more accurate data that the MMIS obtains retroactively on member enrollments, disenrollments, and terminations).	IBP			
MC2.6	Performs mass adjustment to rates according to State policy (e.g., annual adjustment, negotiated rate change, court settlement).	IBP			
MC2.7	Performs periodic reconciliations of State member records with MCO, PCP enrollment records.	IBP			

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MC2 – MAKE ACCURATE PAYMENTS TO MCOs					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC2.8	Verifies correct transfer of capitation payment when member disenrolls from one MCO and enrolls in another plan.	IBP			
MC2.9	Supports ANSI X12N 820 Premium Payment transaction as required by HIPAA.	HIPAA			
MC2SS.1	*Add State-specific criteria for this objective here.*				

MC3 – RECEIVE AND PROCESS ENCOUNTER RECORDS FROM MCOs					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC3.1	Collects and stores encounter data on a periodic basis.	CFR			
MC3.2	Applies key edits to encounter data, e.g., MCO, physician, member ID numbers; diagnosis and procedure codes. (Note: the encounter record edits can be different from claims edits.)	IBP			
MC3.3	Returns erroneous encounter data for correction.	IBP			
MC3.4	Performs adjustments to encounter data.	IBP			
MC3.5	Periodically produces reports for audits on accuracy and timeliness of encounter data, including matching encounter record to MCO paid claim and to the provider's billing.	IBP			

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MC3 – RECEIVE AND PROCESS ENCOUNTER RECORDS FROM MCOs					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC3.6	Able to calculate the "Encounter Cost Value," or the cost of services reported on the encounter claim had they been paid on a fee-for-service basis	IBP			
MC3.7	Accepts and processes encounter claims in formats as mandated by HIPAA, e.g., X12N 837.	HIPAA			
MC3SS.1	*Add State-specific criteria for this objective here.*				

MC4 – PROCESS MCO DATA FOR USE IN ASSESSING QUALITY AND COST OF CARE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC4.1	Accesses and reports on encounter data for the purpose of monitoring appropriateness of care.	CFR			
MC4.2	Accesses and reports on encounter data for use in the determination of re-insurance to calculate true out-of-pocket costs.	IBP			
MC4.3	Accesses and reports on encounter data for use in profiling MCOs and comparing utilization statistics.	IBP			
MC4.4	Collects and sorts encounter data for use in completing MSIS reports.	IBP			
MC4.5	Collects and sorts encounter data for use in determining capitation rates.	IBP			

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MC4 – PROCESS MCO DATA FOR USE IN ASSESSING QUALITY AND COST OF CARE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC4.6	Processes encounter data to detect under-utilization of services by enrollees of the MCO.	CFR			
MC4.7	Matches capitation summary data and fee-for-service (FFS) claims data to verify that the MCO payments do not exceed FFS upper limits.	IBP			
MC4.8	Compares FFS claims statistics and encounter data, re: cost of care, timeliness of care, quality of care, outcomes.	IBP			
MC4.9	Accesses encounter data to identify persons with special health care needs, as specified by the State.	IBP			
MC4.10	Produces reports to identify network providers and assess enrollee access to services.	IBP			
MC4.11	Is able to produce managed care program reports by category of service, category of eligibility, and by provider type.	IBP			
MC4.12	Periodically generates member satisfaction surveys.	IBP			
MC4SS.1	*Add State-specific criteria for this objective here.*				

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MC5 – IDENTIFY MCO-COVERED SERVICES AND BLOCK DUPLICATE PAYMENTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC5.1	Blocks payment to fee-for-service (FFS) providers for services included in the MCO benefit package, with the exceptions stated per the State Plan.	CFR			
MC5.2	Allows fee-for-service (FFS) payment to providers for services carved out of the MCO benefit package. (These services are usually delivered by providers external to the MCO.)	IBP			
MC5.3	Allows payment to fee-for-service (FFS) providers for services rendered in pre-enrollment periods or other periods of transition.	IBP			
MC5.4	Allows payment for treatment obtained by an enrollee for an emergency medical condition without prior authorization.	CFR			
MC5SS.1	*Add State-specific criteria for this objective here.*				

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MC6 – SUPPORT REPORTING OF FINANCIAL INFORMATION					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC6.1	Generates reports of capitation payment by various categories (e.g., by eligibility group, rate cell, etc.).	IBP			
MC6.2	Generates fee-for-service (FFS) claims reporting for services furnished outside of a capitation agreement (i.e., for services "carved-out" of the managed care program).	IBP			
MC6SS.1	*Add State-specific criteria for this objective here.*				

MC7 – SUPPORT MEDICAID MANAGED CARE CONTRACTOR MONITORING (OPTIONAL)					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC7.1	Collects basic administrative information, for instance: - the identification of an MCO - contract start and end dates - contract period/year - capitation effective date - maximum enrollment threshold - enrollee count - member month - re-insurance threshold	IBP			

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MC7 – SUPPORT MEDICAID MANAGED CARE CONTRACTOR MONITORING (OPTIONAL)					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC7SS.1	*Add State-specific criteria for this objective here.*				

MC8 – SUPPORT ADMINISTRATION OF SECTION 1115 WAIVERS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC8.1	Identifies Beneficiaries who are eligible for a State's Medicaid program by qualifying under a Section 1115 waiver eligibility expansion group. Distinguishes the "1115 expansion eligibles" from other groups of Medicaid-eligibles.	IBP			
MC8.2	Collects and maintains the data necessary to support the budget neutrality reporting requirements as specified in the State's 1115 Waiver (including the ability to identify those Beneficiaries who would be ineligible for Medicaid in the absence of the State's 1115 Waiver).	IBP			
MC8SS.1	*Add State-specific criteria for this objective here.*				

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MCSS1 – FIRST STATE-SPECIFIC OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MCSS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.*				