



## Aetna – Contract Compliance Concerns

Item	Issue	State Concern	RFP Section	RFP Language
1	<b>Person-Centered Service Plans</b>	Service plans lacked clear timeframes, specific units, clear language	RFP 5.4.4.1.D	<p>5.4 Service Coordination 5.4.4.1 PLANS OF SERVICE</p> <p>The Plan of Service is a written document that describes and records the Member’s goals and service needs in accordance with State policy. The Plan of Service records the strategies to meet goals and interventions selected by the Member and team to support them in improving the Member’s health and wellbeing and addressing Social Determinants of Health and Independence.</p> <p>5.4.4.1.D The Plan of Service must be compliant with the State’s Plan of Service policy, and shall include the following components:</p> <ol style="list-style-type: none"> <li>1. A description of the Member’s goals, strategies to meet goals and desired health, functional and quality of life Outcomes. For youth Members, inclusion of their family’s goals and strategies shall be incorporated into the Plan of Service.</li> <li>2. Member’s identified strengths, preferences, and any identified needs including psycho-social needs and needs related to social determinations of health and independence such as housing or financial assistance.</li> <li>3. Any services authorized including a detailed description of the amount, scope, and duration of services needed to help meet identified needs or to achieve goals.</li> <li>4. Risk factors, including a Member’s understanding of risk factors and potential adverse consequences, Member’s plans to respond to adverse consequences, and additional measures in place to minimize them, when needed.</li> <li>5. Level of Service Coordination.</li> <li>6. Providers and contact numbers.</li> <li>7. Support systems, relation to Member, and contact numbers including emergency contact.</li> <li>8. Medication list with date and dosages.</li> <li>9. Pharmacy and number.</li> <li>10. Primary language.</li> <li>11. Cultural considerations.</li> <li>12. Treatment plan as appropriate.</li> <li>13. Date of next Service Coordination contact.</li> <li>14. Date of annual reassessment.</li> <li>15. Backup plan per requirements found in 42 CFR § 441.450.</li> <li>16. Patient liability and/or client obligation information including information about Providers to whom the Member has paid.</li> <li>17. The Member’s eligibility start and end date.</li> <li>18. Any specialized communication needs including interpreters or special devices required by the Member. This includes an identification of any reading challenges.</li> <li>19. Any medical equipment used or needed by the Member.</li> <li>20. The Member’s physical environment and any modifications necessary to ensure the Member’s health and safety.</li> </ol>


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1				<p>21. Identification of who is monitoring the plan.</p> <p>22. Service coordinator name and direct contact information along with appropriate off-hours contact information.</p>
2	<p><b>Credentialing and Provider Network</b></p> <p><b>Report and Geo Access Report</b></p>	<p>Various Concerns including:                      Credentialing taking more than 90 days to complete; paperwork for credentialing delayed; providers denied as non-contracted in error.</p> <p>Aetna data is discrepant, cannot determine accuracy of the report, nor network adequacy for Aetna.</p>	<p>5.5.1.I</p> <p>5.5.2.A</p> <p>RFP attachment H introduction, and report #28</p>	<p>5.5 Provider Network</p> <p>5.5.1 Credentialing and Re-Credentialing</p> <p>5.5.1.I Credentialing Timeframes: The CONTRACTOR(S) shall ensure that credentialing of all service Providers applying for Participating Provider status shall be completed within sixty (60) calendar days. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the Provider notifying them of the CONTRACTOR(S)' decision. Credentialed Providers must be entered/loaded into the CONTRACTOR(S)' claims payment system within thirty (30) calendar days of Credentialing Committee approval.</p> <p>5.5.2 Network Development</p> <p>5.5.2 The CONTRACTOR(S) shall develop, maintain, and monitor a network of Providers that:</p> <p>5.5.2.A. Is supported by written agreements and is sufficient in size, scope, and types to deliver all medically necessary Covered Services and satisfy all service delivery requirements in this CONTRACT.</p> <p>CONTRACTOR(S) shall certify data including, but not limited to, all documents specified by the State, enrollment information, encounter data, and other information contained in contracts, proposals. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data.</p>


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2				<p>The CONTRACTOR(S) must provide reports for Medicaid /CHIP populations. These electronic reports must be in Excel and list all Providers' names and addresses, including primary care Providers (PCPs), LTSS Providers, and specialists per the State-provided report template. Providers must have an indicator for open/closed panels and include the number of Members assigned to each provider and provider's maximum caseload. This will be a full file replacement per quarter.</p>
3	<b>Encounters</b>	Claim Copy and Encounter Issues	Attachment J,  1.4.3	 Attachment_J_-_Encounter_Data_and_O <p>1.0 Encounter Data The CONTRACTOR(S) shall collect service information in the federally mandated Health Insurance Portability and Accountability Act (HIPAA) transaction formats and code sets and submit this data in a standardized format approved by the State. The CONTRACTOR(S) must make all collected data available to the State after it is tested for compliance, accuracy, completeness, logic, and consistency. The CONTRACTOR(S) shall follow the encounter data protocol provided in this Attachment and the KanCare Guide located in the Bidder's Library. Periodically, updates to the KanCare Guide will be made. The Kansas Department of Health and Environment (KDHE) will work with the Managed Care Organizations (MCOs) to develop a process that will allow a review and comment period. When updates are made to the KanCare Guide, the changes may need to take effect immediately, i.e. schedules that need to be updated periodically or annually, information that needs to be corrected or clarified and communication that needs to occur due to program changes</p> <p>1.4.3 Timeliness Encounter data shall be submitted within 30 days of claim payment. All encounters must be submitted, both paid and denied claims. The paid claims must include the CONTRACTOR(S)' paid amount.</p>
4	<b>Authorizations that Include Client Obligation</b>	Authorizations for members with client obligation were not built correctly in the Aetna system. System failed to edit for authorizations, causing no claim to	Attachment I  Section 2.1.4	 Attachment_I_-_Claims_Processing.docx <p><b>2.0 Pricing and Financial</b></p>


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4		stop and deduct the client obligation indicated on authorizations.	Section 3.1.22 and 3.1.24	2.1 Processing Requirements 2.1.4 Deduct Member responsibility amounts (patient liability, client obligations, and spenddown) according to State guidelines when pricing claims.  <b>3.0 Adjudication</b> 3.1 Edit/Audit Processing Requirements 3.1.22 Edit for prior authorization (PA) requirements and that the claim matches to an active PA for the date of service. 3.1.24 Update the PA record to reflect the service(s) paid and to update the number of services or dollars remaining to be used on the record.
5	<b>Claims with Client Obligation</b>	Client obligation is either being incorrectly applied, or not applied. Processors did not have proper instructions to deduct the amounts. This creates a huge administrative burden for providers when claims need to be reprocessed.	5.14.1.f.1.B   Attachment 1	5.14 Claims Management 5.14.1 Timely Claims Processing The CONTRACTOR(S) may enter into any payment arrangement with Providers that adequately reimburses Providers for services and supports integrated, coordinated care, including shared saving arrangements to the extent that they do not conflict with Federal or State regulations. However, the CONTRACTOR(S) must pay all claims timely and accurately. The CONTRACTOR(S) is responsible for submitting information about services rendered and reimbursed in the HIPAA-required formats specified in the 837 Institutional Claim and Encounter Transactions, the 837 Professional Services Claim and Encounter Transactions companion guides, the 837 Dental Services Claim and Encounter Transactions and National Council for Prescription Drug Programs (NCPDP) standards, all of which can be found under Publications, HIPAA Companion Guides, at this website: <a href="https://www.kmap-state-ks.us/">https://www.kmap-state-ks.us/</a> . CONTRACTOR(S) shall implement the claims processing requirements set out in Attachment I: KanCare Claims Processing Requirements. F. Nursing Facilities 1. The CONTRACTOR(S) shall: B. Edit claims and claims systems based on patient liability deductions.  Attachment 1 - Claims Processing.docx <b>2.0 Pricing and Financial</b>

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5			2.1.4 (in Attach I).  3.3.1 (in Attach I).	2.1 <u>Processing Requirements</u> <b>2.1.4 Deduct</b> Member responsibility amounts (patient liability, client obligations, and spenddown) according to State guidelines when pricing claims. Note: Please refer to the “Patient Liability, Client Obligation and Spenddown Comparison Chart” in the KanCare Guide  3.0 Adjudication 3.3 Spenddown Requirements 3.3.1 Apply spenddown accurately and timely, every hour, at a minimum, using the Spenddown Web Service
6	<b>Claims</b>	Incorrect provider rates loaded (IHS/RHC/FQHC Rates)	5.5.15.D.2  Attachment I 1.8.1	5.5 Provider Network 5.5.15 PROVIDER PAYMENT 5.5.15.D. FQHC/RHC/Critical Access Hospitals (CAH) Reimbursement: 5.5.15.D.2 The CONTRACTOR(S) shall reimburse an FQHC and RHC the Prospective Payment System rate in effect on the date of service for each Encounter.   Attachment_L_-_Claims_Processing.docx  <u>1.8 CONTRACTOR(S) Responsibilities</u> 1.The CONTRACTOR(S) shall process all claims completely, timely and accurately.
7	<b>Aetna Website Update</b>	Outstanding Website Updates for Contractor and Subcontractors. Various issues.	5.10.4 5.10.5 (Member) 5.6.3 5.6.4 (Provider)	5.10 Member Services 5.10.4 ELECTRONIC SPECIFIC AND WEBSITE REQUIREMENTS FOR MEMBER INFORMATION 5.10.5 WRITTEN MEMBER MATERIALS REQUIREMENTS 5.6 Provider Services 5.6.3 ELECTRONIC SPECIFIC AND WEBSITE REQUIREMENTS FOR PROVIDER INFORMATION 5.6.4 WRITTEN PROVIDER MATERIALS REQUIREMENTS
8	<b>Portal</b>	Providers are still reporting access issues, awaiting provider bulletin for instructions on how to use the portal.	5.6.3.E	5.6 Provider Services 5.6.3 Electronic Specific and Website Requirements for Provider Information 5.6.3.E For Providers, the CONTRACTOR(S) shall maintain a secure area within their website which offers:

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8				3. Electronic copy of explanation of benefits that detail claim service payment or denials. Dates of service, procedure codes, amount billed, amount allowed, amount paid, and patient liability are all required on the explanation of benefits from the CONTRACTOR(S) and Subcontractors.
9	<b>Document and Contract Submissions</b>	Persistent non-compliance with 45 day prior-to-use submittal of documents and contracts. Meeting invitations sent late, or documents sent late for State approval.	RFP 5.6.2.D	<p>5.6 PROVIDER SERVICES The CONTRACTOR(S) shall</p> <p>5.6.2 STATE APPROVAL PROCESS OF PROVIDER MATERIALS 5.6.2.D Except as otherwise noted written materials must be submitted for review at least forty-five (45) calendar days for approval before their printing and distribution. The CONTRACTOR(S) should only request expedited reviews in rare circumstances and will be monitored for potential misuse. This requirement applies to:</p> <ol style="list-style-type: none"> <li>1. Policy letters, coverage policy statements, or other communications about Covered Services distributed to Providers</li> <li>2. All updates to the Provider Handbook</li> <li>3. All bulletins</li> <li>4. All policy information changes submitted via letter</li> <li>5. All Provider CONTRACT templates</li> <li>6. All Pay for Performance (P4P) programs with Providers</li> <li>7. All CONTRACTS with Subcontractors</li> </ol>
10	<b>Contract Reviews</b>	Vendor contracts not approved by KDHE are in use today.	RFP 5.5.13.L	<p>5.5 PROVIDER NETWORK 5.5.13 DELEGATION RELATIONSHIPS 5.5.13.L Each Subcontract, and, upon the request of the State, any further delegations by a Subcontractor, shall be subject to review and/or written approval by the State</p>
11	<b>Problem Notifications</b>	26 so far. 7/16/19 received a problem notification form for an issue that occurred in June.	RFP Attachment I, 5.3	<p> Attachment_I_-_Claims_Processing.docx</p> <p>5.3 Problem Notification Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information, including any problems affecting scheduled exchanges of</p> <p>ATTACHMENT I Page 11 of 11</p>

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11				5.3.1 In its notification, the CONTRACTOR(S) shall: 5.3.1.1 Explain in detail the impact to critical path processes such as enrollment management and claims submission processes. 5.3.1.2 Submit an MCO Problem Notification Form by the end of the next business day after discovery of a system deficiency is identified.