APPENDIX V – Information Systems Capabilities Assessment

Attachment A: Tools for Assessing MCO Information Systems

INFORMATION SYSTEM CAPABILITIES ASSESSMENT (ISCA) TOOL

This tool was developed in 2001 for inclusion in the original EQR Protocol package. This tool will be replaced with an updated tool after CMS completes a business intelligence analysis currently underway. The purpose of the tool remains the validation of information systems, processes, and data from providers and MCOs.

The ISCA is an information collection tool provided to the MCO by the State or its EQRO. The State or EQRO will define a time frame in which the MCO is expected to complete and return the tool. The MCO will record data on the provided tool. Documents from the MCO are requested throughout the tool and are summarized on the checklist at the end of this assessment tool. These documents should be attached to the tool and be identified as applicable to the numbered item on the tool (e.g., II.B.3 or IV.6). The tool itself is based on that produced by MEDSTAT Group, Inc., with some additional elements included to address the multiple purposes of performing assessments of information systems.

Note: The information requested below pertains to the collection and processing of data for an MCO's Medicaid line of business. In many situations, if not most, this may be no different than how an MCO collects and processes commercial or Medicare data. However, for questions which may address areas where Medicaid data is managed differently than commercial or other data, please provide the answers to the questions as they relate to Medicaid enrollees and Medicaid data.

A. Contact Information

Please insert (or verify the accuracy of) the MCO identification information below, including the MCO name, MCO contact name and title, mailing address, telephone and fax numbers, and E-mail address, if applicable.

MCO Name:	
Contact Name and Title:	
Mailing address:	
Phone number:	
Fax number:	
E-mail address:	

B. Managed Care Model Type (Please circle one, or specify other.)

MCO-staff model MCO-group model MCO-IPA model MCO-mixed model PIHP

Other - specify:_____

C. Year Incorporated _____

D. Member Enrollment for the Last Three Years.

INSURER	Year 1:_____	Year 2 _____	Year 3:_____
Privately Insured			
Medicare			
Medicaid			
Other			

E. Has your organization ever undergone a formal information system capability assessment?

Circle a response: Yes No

If yes, who performed the assessment?

When was the assessment completed?

NOTE: If your MCO's information has been formally assessed in the recent past (2 years or less), please attach a copy of the assessment report. Complete only those sections of the ISCA that are not covered by or have changed since the formal assessment was conducted.

INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES & PERSONNEL

1. What data base management system(s) (DBMS) do/does your organization use to store Medicaid claims and encounter data?

2. How would you characterize this/these DBMSs? (Circle all that apply.)
   A. Relational B. Network
   C. Hierarchical D. Flat File
   E. Indexed F. Proprietary
   G. Other H. Don't Know

3. Into what DBMS(s), if any, do you extract relevant Medicaid encounter/claim/enrollment detail for analytic reporting purposes?

4. How would you characterize this/these DBMS(s)? (Circle all that apply.)
   A. Relational B. Network
   C. Hierarchical D. Flat File
   E. Indexed F. Proprietary
   G. Other H. Don't Know

5. What programming language(s) do your programmers use to create Medicaid data extracts or analytic reports? How many programmers are trained and capable of modifying these programs?

6. Do you calculate defect rates for programs?

   Circle your response. Yes No

   If yes, what methods do you use to calculate the defect rate?

   What was the most recent time period?

   What were the results?

7. Do you rely on any quantitative measures of programmer performance? If so, what method(s) do you use to measure the effectiveness of the programmer?

8. Approximately what percentage of your organization's programming work is outsourced? _____%

9. What is the average experience, in years, of programmers in your organization?

10. Approximately how many resources (time, money, etc.) are spent on training per programmer per year? What type of standard training for programmers is provided? What type of additional training is provided?

11. What is the programmer turnover rate for each of the last 3 years (new programmers per year/total programmers)?

    Year 1 (20xx): _____ % Year 2 (20xx): _____ % Year 3 (20xx): _____ %

12. Outline the steps of the maintenance cycle for your State's mandated Medicaid reporting requirement(s). Include any tasks related to documentation, debugging, roll out, training, etc. The level of detail should result in 10-25 steps in the outline.

13. What is the process for version control when code is revised?

14. How does your organization know if changes to the claims/encounter/enrollment tracking system affect required reporting to the State Medicaid program? What prompts your organization to change these systems?

15. Who is responsible for your organization meeting the State Medicaid reporting requirements (e.g., CEO, CFO, and COO)?

16. Staffing

    16a. Describe the Medicaid data processing organization in terms of staffing and their expected productivity goals. What is the overall daily, monthly, and annual productivity of overall department and by processor?

16b. Describe processor training from new hire to refresher courses for seasoned processors.

16c. What is the average tenure of the staff? What is annual turnover?

17. Security

17a. Describe how loss of Medicaid claim and encounter and other related data is prevented when systems fail? How frequently are system back-ups performed? Where is back-up data stored? How and how often are the backups tested to make sure that the back-up is functional?

17b. How is Medicaid data corruption prevented due to system failure or program error?

17c. Describe the controls used to assure all Medicaid claims data entered into the system is fully accounted for (e.g., batch control sheets).

17d. Describe the provisions in place for physical security of the computer system and manual files:

- Premises
- Documents
- Computer facilities
- Terminal access and levels of security

17e. What other individuals have access to the computer system? Customers? Providers? Describe their access and the security that is maintained restricting or controlling such access.

DATA ACQUISITION CAPABILITIES

The purpose of this section is to obtain a high-level understanding of how you collect and maintain claims/encounters, enrollment information, and data on ancillary services such as prescription drugs.

A. Administrative Data (Claims and Encounter Data)

This section requests information on input data sources (e.g., paper and electronic claims) and on the transaction system(s) you use.

1. Do you use standard claims or encounter forms for the following? If yes, please specify (e.g., CMS1500, UB 92).

DATA SOURCE	NO	YES	IF YES, PLEASE SPECIFY
Hospital			
Physician			
Drug			
Nursing Home			
Home Health			
Mental Health			
Dental			

2. We would like to understand how claims or encounters are submitted to your plan. We are also interested in an estimate of what percentage (if any) of services provided to your enrollees by all providers serving your Medicaid enrollees are NOT submitted as claims or encounters, and therefore, are not represented in your administrative data. Please fill in the following table with the appropriate percentages:

CLAIMS OR ENCOUNTER TYPES

MEDIUM	Hospital	PCP	Specialist Physician	Dental	Mental health/ Substance abuse	Drug	Other
Claims/encounters submitted electronically							
Claims/encounters submitted on paper							
Services not submitted as claims or encounters							
TOTAL	100%	100%	100%	100%	100%	100%	100%

3. Please document whether the following data elements (data fields) are required by you for providers, for each of the types of Medicaid claims/encounters identified below. If required, enter an “R” in the appropriate box.

CLAIMS/ENCOUNTER TYPES

DATA ELEMENTS	Hospital	Primary Care Physician	Specialist Physician	Mental Health/ Substance Abuse	Dental	Drug	Other
Patient Gender							
Patient DOB/Age							
Diagnosis							
Procedure							
First Date of Service							
Last Date of Service							
Revenue Code							
Provider Specialty							

4. How many diagnoses and procedures are captured on each claim? On each encounter?

	Claim		Encounter	
	Diagnoses	Procedures	Diagnoses	Procedures
Institutional Data				
Provider/Provider Group Data				

5. Can you distinguish between principal and secondary diagnoses?

   Circle your response. Yes No

5a. If "Yes" to 5a, above, how do you distinguish between principal and secondary diagnoses?

6. Please explain what happens if a Medicaid claim/encounter is submitted and one or more required fields are missing, incomplete, or invalid. For example, if diagnosis is not coded, is the claims examiner required by the system to use an on-line software product like AutoCoder to determine the correct ICD-9/10 code?

   Institutional Data:

   Professional Data:

7. What steps do you take to verify the accuracy of submitted information (e.g., procedure code- diagnosis edits, gender-diagnosis edits, gender-procedure code edits)?

Institutional Data:

Professional Data:

8. Under what circumstances can claims processors change Medicaid claims/encounter information?

9. Identify any instance where the content of a field is intentionally different from the description or intended use of the field. For example, if the dependent's SSN is unknown, do you enter the member's SSN instead?

10a. How are Medicaid claims/encounters received?

SOURCE	Received Directly from Provider	Submitted through an Intermediary
Hospital		
Physician		
Pharmacy		
Nursing Home		
Home Health		
Mental health		
Dental		
Other		

10b. If the data are received through an intermediary, what changes, if any, are made to the data?

11. Please estimate the percentage of Medicaid claims/encounters that are coded using the following coding schemes:

CODING SCHEME	Inpatient Diagnosis	Inpatient Procedure	Ambulatory/ Outpatient Diagnosis	Ambulatory/ Outpatient Procedure	Drug
ICD-9/10 CM					
CPT-4					
HCPCS					
DSM-IV					
National Drug Code					
Internally Developed					
Other (specify)					
Not required					
TOTAL	100%	100%	100%	100%	100%

12. Please identify all information systems through which service and utilization data for the Medicaid population is processed.

13. Please describe any major systems changes/updates that have taken place in the last three years in your Medicaid claims or encounter system (be sure to provide specific dates on which changes were implemented).

    - New system purchased and installed to replace old system.
    - New system purchased and installed to replace most of old system; old system still used.
    - Major enhancements to old system (what kinds of enhancements?).
    - New product line adjudicated on old system.
    - Conversion of a product line from one system to another.

14. In your opinion, have any of these changes influenced, even temporarily, the quality and/or completeness of the Medicaid data that are collected? If so, how and when?

15. How many years of Medicaid data are retained on-line? How is historical Medicaid data accessed when needed?

16. How much Medicaid data is processed on-line vs. batch? If batch, how often are they run?

17. How complete are the Medicaid data three months after the close of the reporting period? How is completeness estimated? How is completeness defined?

18. What is your policy regarding Medicaid claim/encounter audits? Are Medicaid encounters audited regularly? Randomly? What are the standards regarding timeliness of processing?

19. Please provide detail on system edits that are targeted to field content and consistency. Are diagnostic and procedure codes edited for validity?

20. Please complete the following table for Medicaid claims and encounter data and other Medicaid administrative data. Provide any documentation that should be reviewed to explain the data that is being submitted.

	Claims	**Encounters**	**Other Administrative Data**
Percent of total service volume			
Percent complete			
How are the above statistics quantified?			
Incentives for data submission			

21. Describe the Medicaid claims/encounter suspend ("pend") process including timeliness of reconciling pended services.

22. Describe how Medicaid claims are suspended/pended for medical review, for non-approval due to missing authorization code(s) or for other reasons. What triggers a processor to follow up on "pended" claims? How frequent are these triggers?

23. If any Medicaid services/providers are capitated, have you performed studies on the completeness of the information collected on capitated services? If yes, what were the results?

24a. Identify the claim/encounter system(s) for each product line offered to Medicaid enrollees. (Note: Typically, there is just one product line offered to Medicaid enrollees, but there may be some circumstances in which a MCO offers additional product lines to the State (e.g., CHIP, partial risk products).

Systems Used to Process	Product Line:_____	Product Line: _____	Product Line:_____
Fee-for-service (indemnity) claims			
Capitated service encounters			
Clinic patient registrations			
Pharmacy claims			
Other (describe)			

24b. If multiple systems are used to process claims for the Medicaid product line, document how claims/encounters are ultimately merged into Medicaid-specific files--and on which platform?

Note which merges or data transfers or downloads are automated and which rely on manual processes.

Are these merges and/or transfers performed in batch? With what frequency?

24c. Beginning with receipt of a Medicaid claim in-house, describe the claim handling, logging, and processes that precede adjudication. When are Medicaid claims assigned a document control number and logged or scanned into the system? When are Medicaid claims microfilmed? If there is a delay in microfilming, how do processors access a claim that is logged into the system, but is not yet filmed?

24d. Please provide a detailed description of each system or process that is involved in adjudicating:

- A professional encounter(s) for a capitated service (e.g., child immunizations that arrive separately from the office visit.)
- A hospital claim for a delivery or for a newborn that exceeds its mother's stay.

24e. Discuss which decisions in processing a Medicaid claim/encounter are automated, which are prompted by automated messages appearing on the screen, and which are manual. Document the opportunities a processor has for overriding the system manually. Is there a report documenting over-rides or "exceptions" generated on each processor and reviewed by the claim supervisor? If so, please describe this report.

24f. Are there any outside parties or contractors used to complete adjudication, including but not limited to:

- Bill auditors (hospital claims, claims over a certain dollar amount)

- Peer or medical reviewers
- Sources for additional charge data (usual & customary)
- Bill “re-pricing” for carved out benefits (mental health, substance abuse)

How is this data incorporated into your organization’s data?

24g. Describe the system’s editing capabilities that assure that Medicaid claims are correctly adjudicated
- Provide a list of the specific edits that are performed on claims as they are adjudicated, and note: 1) whether the edits are performed pre or post-payment, and 2) which are manual and which are automated functions.

24h. Discuss the routine and non-routine (ad hoc or special) audits that are performed on claims/encounters to assure the quality and accuracy and timeliness of processing. Note which audits are performed per processor, which rely on targeted samples, and which use random sampling techniques. What is the total percentage of claims on-hand that are audited through these QA processes? How frequently?

24i. Please describe how Medicaid eligibility files are updated, how frequently and who has “change” authority. How and when does Medicaid eligibility verification take place?

24j. How are encounters for capitated services handled by payment functions? What message appears to notify processors that they are handling a capitated service?

24k. Describe how your systems and procedures handle validation and payment of Medicaid claims when procedure codes are not provided.

24l. Where does the system-generated output (EOBs, letters, etc.) reside? In-house? In a separate facility? If located elsewhere, how is such work tracked and accounted for?

25a. Describe all performance monitoring standards for Medicaid claims/encounters processing and recent actual performance results.

25b. Describe processor-specific performance goals and supervision of actual vs. target performance. Do processors have to meet goals for processing speed? Do they have to meet goals for accuracy?

25c. How is performance against targets figured into the official performance appraisal process? Into processor and supervisor compensation?

B. Enrollment System

1. Please describe any major changes/updates that have taken place in the last three years in your Medicaid enrollment data system (be sure to identify specific dates on which changes were implemented). For example:

- New enrollment system purchased and installed to replace old system
- New enrollment system purchased and installed to replace most of old system - is old system still used
- Major enhancements to old system (what kinds of enhancements?)
- New product line members stored on old system

2. In your opinion, have any of these changes influenced, even temporarily, the quality and/or completeness of the Medicaid data that are collected? If so, how and when?

3. How does your plan uniquely identify enrollees?

4. How do you handle enrollee disenrollment and re-enrollment in the Medicaid product line? Does the member retain the same ID?

5. Can your systems track enrollees who switch from one product line (e.g., Medicaid, commercial plan, Medicare) to another? Circle your response. Yes No

5a. Can you track an enrollee's initial enrollment date with your MCO or is a new enrollment date assigned when a member enrolls in a new product line?

5b. Can you track previous claim/encounter data or are you unable to link previous claim/encounter data across product lines?

6. Under what circumstances, if any, can a Medicaid member exist under more than one identification number within your MCO's information management systems? Under what circumstances, if any, can a member's identification number change?

7. How does your MCO enroll and track newborns born to an existing Medicaid enrollee?

7a. If your MCO has a Medicare product line, describe how your enrollment systems link individuals simultaneously enrolled in both your Medicare product line and the Medicaid plan product line.

8a. Is claim/encounter data linked for Medicare/Medicaid dual eligibles so that all encounter data can be identified for the purposes of performance measure reporting?

Circle your response. Yes No

8b. Is claim/encounter data linked for individuals enrolled in both a Medicare and Medicaid plan so that all encounter data can be identified for the purposes of performance measure reporting? Circle your response. Yes No

9. How often is Medicaid enrollment information updated?

10. How is Medicaid continuous enrollment being defined? In particular, does your system have any limitations that preclude you from fully implementing continuous enrollment requirements exactly as specified in the State performance measure requirements?

11. Please attach a copy of the source code that you use to calculate Medicaid continuous enrollment.

12. How do you handle breaks in Medicaid enrollment--e.g., situations where a Medicaid enrollee is disenrolled one day and re-enrolled the next simply for administrative reasons? Does this affect your continuous enrollment calculations?

13. Do you have restrictions on when Medicaid enrollees can enroll or disenroll? Please describe.

14. How do you identify and count Medicaid member months? Medicaid member years?

15. Please identify all data from which claims/encounters for the Medicaid product line are verified.

16. Does the plan offer vision or pharmacy benefits to its Medicaid members that are different from the vision or pharmacy benefits offered to its commercial enrollees (within a given contract or market area)? Circle your response. Yes No If yes, explain:

16a. If vision benefits vary by benefit package, outline the different options available. How are enrollees tracked?

16b. If pharmacy benefits vary by benefit package, outline the different options available. How are enrollees tracked?

C. Ancillary Systems

Use this section to record information on stand-alone systems or benefits provided through subcontracts, such as pharmacy or mental health/substance abuse.

1. Does your MCO incorporate data from vendors to calculate any of the following Medicaid quality measures? If so, which measures require vendor data?

NOTE: The measures listed in the following table are examples of measures that can be calculated with administrative data and align with CMS quality measurement initiatives as of 2011. The State and EQRO should tailor this table to list those measures that the State requires its MCO contractors to produce and any other measures in which the State is interested. Measures denoted with an asterisk are part of either the CHIPRA or Medicaid adult core measure sets.

MEASURE	VENDOR NAME
Childhood and Adolescent Immunization Rate(s)*	
Well Child Visits*	
Adolescent Well-Care Visits*	
Initiation of Prenatal Care	
Prenatal and Postpartum Care: Timeliness of Prenatal Care*	
Frequency of Ongoing Prenatal Care*	
Developmental Screening In the First Three Years of Life*	
Cervical Cancer Screening	
Chlamydia Screening in Women*	
Child and Adolescent Access to Primary Care Practitioners*	
Percentage of Eligibles Who Received Preventive Dental Services*	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/ Adolescents*	
Breast Cancer Screening (Mammography	
Glycohemoglobin Monitoring	
Annual Pediatric Hemoglobin A1C Testing*	
Provider Certification	
Appropriate Testing for Children with Pharyngitis*	
Otitis Media with Effusion (OME) – Avoidance of Inappropriate Use of Systemic Antimicrobials in Children*	
Percentage of Eligibles who Received Dental Treatment Services*	
Ambulatory Care: Emergency Department Visits*	
Annual Percentage of Asthma Patients 2 Through 20 Years Old with One or More Asthma-Related Emergency Room Visits*	
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication*	
Follow-up After Hospitalization for Mental Illness*	

2. Discuss any concerns you may have about the quality or completeness of any vendor data.

3. Please list subcontracted Medicaid benefits that are adjudicated through a separate system that belongs to a vendor.

4. Describe the kinds of information sources available to the MCO from the vendor (e.g., monthly hard copy reports, full claims data).

5. Do you evaluate the quality of this information? If so, how?

6. Did you incorporate these vendor data into the creation of Medicaid-related studies? If not, why not?

D. Integration and Control of Data for Performance Measure Reporting

This section requests information on how your MCO integrates Medicaid claims, encounter, membership, provider, vendor, and other data to calculate performance rates. All questions relate to your current systems and processes, unless indicated otherwise.

1. Please attach a flowchart outlining the structure of your management information systems, indicating data integration (i.e., claims files, encounter files, etc.). For an example of the minimum level of detail requested, please refer to the example on page 38. Label the attachment II.D.1.

2. In consolidating data for Medicaid performance measurement, how are the data sets for each measure collected:

   - By querying the processing system online?

   - By using extract files created for analytical purposes? If so, how frequently are the files updated? How do they account for claim and encounter submission and processing lags? How is the file creation process checked for accuracy?

   - By using a separate relational database or data warehouse (i.e., a performance measure repository)? If so, is this the same system from which all other reporting is produced?

3. Describe the procedure for consolidating Medicaid claims/encounter, member, and provider data for performance measure reporting (whether it is into a relational database or file extracts on a measure-by-measure basis).

   3a. How many different sources of data are merged together to create reports?

   3b. What control processes are in place to ensure data merges are accurate and complete?

3c. What control processes are in place to ensure that no extraneous data are captured (e.g., lack of specificity in patient identifiers may lead to inclusion of non-eligible members or to double counting)?

3d. Do you compare samples of data in the repository to transaction files to verify if all the required data are captured (e.g., were any members, providers, or services lost in the process)?

3e. Describe your process(es) to monitor that the required level of coding detail is maintained (e.g., all significant digits, primary and secondary diagnoses remain)?

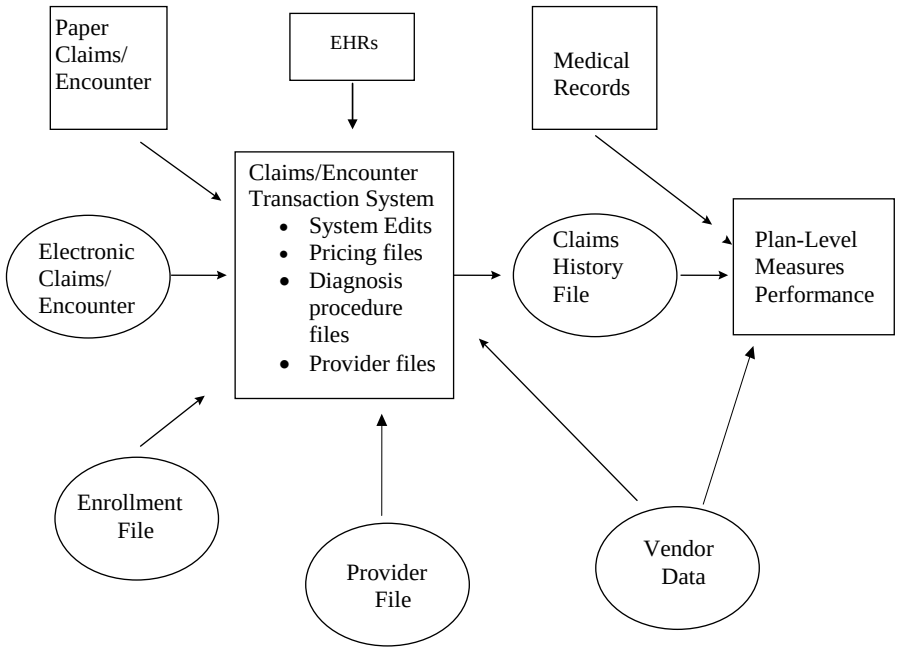
4. Describe both the files accessed to create Medicaid performance measures and the fields from those files used for linking or analysis. Use either a schematic or text to respond.

5. Are any algorithms used to check the reasonableness of data integrated to report Medicaid performance measures?

6. Are Medicaid reports created from a vendor software product? If so, how frequently are the files updated? How are reports checked for accuracy?

7. Are data files used to report Medicaid performance measures archived and labeled with the performance period in question?

Performance Measure Data: Flowchart of Information System Structure



Vendor Data Integration

7. Information on several types of external encounter sources is requested. In the table on the following page, for each type of delegated service, please indicate the following:

   - Second column: Indicate the number of vendors contracted (or subcontracted) to provide the Medicaid service. Include vendors that offer all or some of the service.

   - Third column: Indicate whether your MCO receives member-level data for any Medicaid performance measure reporting from the vendor(s). Only answer "Yes" if all data received from contracted vendor(s) are at the member level. If any encounter-related data is received in aggregate form, you should answer "No". If type of service is not a covered benefit, indicate "N/A".

   - Fourth column: Indicate whether all data needed for Medicaid performance measure reporting are integrated, at the member-level, with MCO administrative data.

   - Fifth and sixth columns: rank the completeness and quality of the Medicaid data provided by the vendor(s). Consider data received from all sources when using the following data quality grades:

     A. Data are complete or of high quality
     B. Data are generally complete or of good quality
     C. Data are incomplete or of poor quality

- In the seventh column, describe any concerns you have in ensuring completeness and quality of Medicaid data received from contracted vendors. If measure is not being calculated because of any eligible members, please indicate “N/A”.

Medicaid Claim/Encounter Data from Vendors

Type of Delegated Service	Number of Contracted Vendors	Always receive member-level data from all vendor(s)? (Yes or No)	Integrate vendor data with MCO administrative data? (Yes or No)	Completeness of Data (A, B, or C)	Quality of Data (A, B, or C)	Rationale for Rating/ Concerns with Data Collection
Behavioral Health						
Family Planning						
Home Health Care						
Hospital						
Laboratory						
Pharmacy						
Primary Care						
Radiology						
Specialty Care						
Vision Care						
Dental for Children						

Performance Measure Repository Structure

If your MCO uses a performance measure repository, please answer the following question. Otherwise, skip to the Report Production section.

9. If your MCO uses a performance measure repository for Medicaid performance measures, review the repository structure. Does it contain all the key information necessary for Medicaid performance measure reporting?

Report Production

10. Please describe your Medicaid report production logs and run controls. Please describe your Medicaid performance measure report generation process.

11. How are Medicaid report generation programs documented? Is there a type of version control in place?

12. How does your MCO test the process used to create Medicaid performance measure reports?

13. Are Medicaid performance measure reporting programs reviewed by supervisory staff?

14. Do you have internal back-ups for performance measure programmers (i.e., do others know the programming language and the structure of the actual programs)? Is there documentation?

15. How are revisions to Medicaid claims, encounters, membership, and provider data systems managed?

PROVIDER DATA

Compensation Structure

The purpose of this section is to evaluate the Medicaid provider compensation structure, as this may influence the quality and completeness of data. Please identify the percentage of member months in your plan contributed by Medicaid members whose primary care providers and specialists are compensated through each of the following payment mechanisms.

PAYMENT MECHANISM	Primary Care Physician	Specialist Physician
1. Salaried		
2. Fee-for-Service, no withhold or bonus		
3. Fee-for-Service, with withhold Please specify % withhold:		
4. Fee-for-Service with bonus Bonus range:		
5. Capitated - no withhold or bonus		
6. Capitated with withhold Please specify % withhold:		
7. Capitated with bonus Bonus range:		
8. Other		
TOTAL	100%	100%

9. Please describe how Medicaid provider directories are updated, how frequently, and who has “change” authority.

9a. Does your MCO maintain provider profiles in its information system?

Please circle response: YES NO

9b. If yes to "a," what provider information is maintained in the provider profile database (e.g., languages spoken, special accessibility for individuals with special health care needs). Other? Please describe:

10. How are Medicaid fee schedules and provider compensation rules maintained? Who has updating authority?

11. Are Medicaid fee schedules and contractual payment terms automated? Is payment against the schedules automated for all types of participating providers?

Summary of Requested Documentation

The documentation requested in the previous questions is summarized in the table below. Please label all attached documentation as described in the table, and when applicable by the item number from the ISCA (e.g., III.B.10). Remember, you are not limited to providing only the documentation listed below; you are encouraged to provide any additional documentation that helps clarify an answer or eliminates the need for a lengthy response.

Requested Document	Details
Previous Medicaid Performance Measure Audit Reports	Please attach final reports from any previous Medicaid performance measure audits in which your MCO participated during the past two years.
Organizational Chart	Please attach an organizational chart for your MCO. The chart should make clear the relationship among key Individuals/departments responsible for information management, including performance measure reporting.
Data Integration Flow Chart	Please provide a flowchart that gives an overview of the structure of your management information system. See the example provided in Section II-D. "Integration and Control of Data for Performance Measure Reporting." Be sure to show how all claims, encounter, membership, provider, EHR, and vendor data are integrated for performance measure reporting.
Performance Measure Repository File Structure (if applicable)	Provide a complete file structure, file format, and field definitions for the performance measure repository.
Program/Query Language for Performance Measure Repository Reporting (if applicable)	Provide full documentation on the software programs or codes used to convert performance measure repository data to performance measures.
Continuous Enrollment Source Code	Attach a copy of the source code/computer programs that you use to calculate continuous enrollment for

Requested Document	Details
	Medicaid enrollees.
Medicaid Member Months Source Code	Attach a copy of the source code/computer programs that you use to calculate member months, member years for Medicaid enrollees.
Medicaid Claims Edits	List of specific edits performed on claims as they are adjudicated with notation of performance timing (pre or post-payment) and whether they are manual or automated functions.
Statistics on Medicaid claims/encounters and other administrative data	Documentation that explains statistics reported in the ISCA.