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| **Community Health Plan of Washington (MCO)**  **Claims and Encounters Delegation Grid** |

The purpose of the following grid is to specify the responsibilities of [name Delegate] (“Delegate”) under the Agreement with respect to the specific activities that are delegated regarding Claims and Encounter Data. The grid also describes the reporting requirements, which are in addition to any applicable reporting requirements stated in the Agreement. The grid below applies to the delegation of Claims Processing and Payment and Encounter Data Submission by MCO to Delegate.

The delegation grid may be amended from time to time during the term of the Agreement by MCO to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which MCO evaluates Delegate’s performance and the remedies available to MCO if Delegate does not fulfill its obligations. The statements below shall not supersede any term or condition of Exhibit A, the Delegation Agreement, and all obligations and remedies set forth in the parties’ Agreement remain in full force and effect. In the event of a conflict between the descriptions below and any term or condition of the Agreement, including Exhibit A, the terms and conditions of the Agreement shall prevail.

**Process of Evaluating Delegate’s Performance**

MCO will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Delegate performance on an ongoing basis. In addition, MCO will:

* Conduct an annual audit to ensure all delegated activities comply with applicable Compliance Requirements,
* Provide written feedback on the results of the annual audit, and
* Require Delegate to implement corrective action plans if the delegate does not fully meet Compliance Requirements.

If MCO determines that Delegate has failed to adequately perform the delegated activities, MCO may:

* Change or revoke the scope of delegation if corrective action is not adequate; and/or
* Discontinue contracting with Delegate.

Ongoing performance of accredited delegates is evaluated through the semi-annual and routine monitoring of reports. MCO reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

**Corrective Action Plans**

If Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, MCO will work with Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If Delegate does not take corrective action, or fails to meet improvement goals, MCO reserves the right to revise the delegation agreement and scope, or revoke the delegation agreement altogether.

**Subdelegation**

It may be allowable for Delegate to subdelegate specific activities that relate to Claims and Encounter Data. As provided for under the Agreement and as set forth herein, subdelegation requires the prior written approval of MCO. In addition to the requirements for subdelegation set forth in the Agreement, Delegate will submit to MCO a Delegation Chart (template to be provided by MCO). If a subdelegation is approved, the Delegate will be responsible for ongoing oversight of the subdelegate’s performance and will be required to report performance results to MCO.

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| **CLAIMS/ENCOUNTER BUSINESS REQUIREMENTS** | | | | |
| **Function** | **Delegation Status** | **Delegate**  **Activities** | **Reporting: Data, Frequency, & Submission** | **MCO**  **Activities** |
| 1. Encounter Data  Definition of Encounter Data | Delegated  Not Delegated | Encounter Data means records of physical or behavioral health care services submitted as electronic data files created by the BHASO’s system in the standard 837 format and the National Council for Prescription Drug Programs (NCPDP) Batch format. | N/A | N/A |
| 2. Encounter Data  Dedicated Resource | Delegated  Not Delegated | Designate a person dedicated to work collaboratively with MCO on quality control and review of encounter data submitted to HCA. | N/A | MCO resource will partner with BHASO resource for quality control and review of encounter data. |
| 3. Encounter Data  Reporting requirements | Delegated  Not Delegated | Submit complete, accurate, and timely data for all services for which the BHASO has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA. | Weekly | MCO will provide oversight of BHASO encounter data. |
| 4. Encounter Data  Expected turnaround time reporting encounter data | Delegated  Not Delegated | Encounter data must be submitted to MCO at a minimum weekly, and no later than thirty (30) calendar days from the end of the month in which the BHASO paid the financial liability. | Weekly | MCO will monitor turnaround. |
| 5. Encounter Data  Submission and edits | Delegated  Not Delegated | Submitted encounters and encounter records must pass all system edits with a disposition of accept and listed in the Encounter Data Reporting Guide or sent out in communications from HCA to the BHASO. | N/A | N/A |
| 6. Encounter Data  Duplicates | Delegated  Not Delegated | Submitted encounters or encounter records must not be a duplicate of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA Transaction Standards. | N/A | N/A |
| 7. Encounter Data  RCW 42.56.270(11) | Delegated  Not Delegated | The BHASO must report the paid date, paid unit, and paid amount for each encounter. The “paid amount” data is considered the BHASO’s proprietary information and is protected from public disclosure.  “Paid amount” is defined as the amount paid for the service, or zero pay for cost based/invoice payments. | N/A | N/A |
| 8. Encounter Data  42 C.F.R. § 438.606  Attestations | Delegated  Not Delegated | The BHASO shall send attestation to MCO to certify the accuracy and completeness of all encounter data concurrently with each file upload. | Weekly | MCO will receive monthly attestations from the BHASO. MCO will review and complete the monthly certification letter and send to the HCA. |
| 9. Encounter Data  837 Requirements | Delegated  Not Delegated | THE BHASO must be able to meet the requirements outlined in the following requirements document. | N/A | N/A |
| 10. Encounter Data  Quality Assurance | Delegated  Not Delegated | The BHASO must validate the accuracy and completeness of all encounter data for behavioral health care services compared to the year-to-date general ledger of paid claims for the health care services. | Quarterly | MCO will oversee the quality assurance of the BHASO encounters. |
| 11. Encounter Data  Form D | Delegated  Not Delegated | Within sixty (60) calendar days of the end of each calendar quarter, the BHASO shall provide aggregate totals of all encounter data submitted and accepted during that quarter on the Apple Health - Integrated Managed Care Quarterly Encounter/General Ledger Reconciliation (Form D). BHASO shall reconcile the cumulative encounter data submitted and accepted for the quarter and contract year with the general ledger paid claims for the quarter. The BHASO shall provide justification for any discrepancies.  BHASO will complete Form D and send to MCO.  HCA will approve or reject the discrepancy justifications and notify the MCO of the decision 120 calendar days of the end of each calendar quarter. | Quarterly | MCO will submit Form D to HCA. |
| 12. Claims Payment Standards  Section 1902(a)(37) of the Social Security Act  42 C.F.R. § 447.46  WAC 284-170-431 | Delegated  Not Delegated | The BHASO shall meet the timeliness of payment standards. These standards shall also be applicable to State-only and federal block grant fund payments.  To be compliant with payment standards the BHASO shall pay or deny 95 percent of clean claims within thirty (30) calendar days of receipt, 95 percent of all claims within sixty (60) calendar days of receipt and 95 percent of clean claims within ninety (90) calendar days of receipt.  The BHASO shall provide a monthly report to the MCO of claims timeliness results. If standard is not met, provide root cause and corrective action until performance expectation is met. | Monthly | MCO will monitor timeliness of claims payment standards. |
| 13. Claims processing  Top Claims Denials Reporting | Delegated  Not Delegated | The BHASO shall produce and submit a quarterly claims denial analysis report. The first report due May 31st 2019 for services processed January – March 2019. The report shall include the following data:  Total number of approved claims for which there was at least one denied line.  Completely denied claims.  Total number of claims adjudicated in the reporting claim.  Total number of behavioral health claims denied by claim line.  Summary by reason and type of claims denied.  The total number of denied claims divided by the total number of claims.  For each of the five network billing providers with the highest number of total denied claims, the number of total denied claims expressed as a ratio to all claims adjudicated.  Total number of Behavioral Health claims received, that were not approved upon initial submission.  The total number of rejected/non-clean behavioral health claims, divided by the total number of claims submitted.  The top five reasons for behavioral health claims being rejected upon initial submission.  The report shall include a narrative, including the action steps planned to address.  The top five (5) reasons for denial, including provider education to the five network billing providers with the highest number of total denied claims. Provider education must address root causes of denied claims and actions to address them. | Quarterly | MCO will review denials, and may report up to the HCA. |
| 14. TPL Reporting | Delegated  Not Delegated | The BHASO shall submit a quarterly *Recovery and Cost Avoidance Report* that  includes any recoveries for third party resources as well as claims that the BHASO  denies due to TPL coverage. The report shall include recoveries or denied claim  payments for any covered service. The BHASO shall calculate cost savings in  categories. The BHASO shall treat funds recovered from third  parties as offsets to claims payments and reflect those offsets in encounter data.  The report is due by the sixtieth (60th) calendar day following the  end of the quarter.  The BHASO shall submit to the MCO on the 15th of the month following the end of the  monthly reporting period a report (Enrollees with Other Health Care Insurance) of  Enrollees with any other health care insurance coverage with any carrier, including the BHASO.  The BHASO shall submit to the MCO on the 20th of the following month a report  (Subrogation Rights of Third Party Liability (TPL) – Investigations) of any Enrollees who  the BHASO newly becomes aware of a cause of action to recover health care costs  for which the BHASO has paid under the Agreement. | Monthly | MCO will review and report outcome to the HCA. |
| 15. Participating and Non-Participating Reporting | Delegated  Not Delegated | The BHASO shall track and record all payments to Participating Providers and Non-  Participating Providers in a manner that allows for reporting to the MCO the number,  amount, and percentage of claims paid to Participating Providers and Non-Participating  Providers separately. The BHASO shall identify the type of providers and  Subspecialty. The BHASO shall also  track, document and report to the MCO any known attempt by Non-Participating Providers  to balance bill Enrollees.  The BHASO shall provide annual reports to the MCO for the preceding state fiscal  year (July 1 through June 30). The reports shall indicate the proportion of services  provided by the BHASO’s Participating Providers and Non-Participating Providers, by  county, and including hospital-based physician services.  BHASO shall submit the reports to the MCO no later than August 15 of each year. |  | MCO will monitor, and may report up to the HCA. |
| 16. Sub-delegation Agreements  BHASO sub-delegation agreements with a vendor | Delegated  Not Delegated | Notify the MCO of sub-delegation vendor agreements the BHASO has; what duties do they perform, and how often. |  | N/A |
| 17.Claims/Encounter Delegation Oversight Audit  Quality Assurance Audits | Delegated  Not Delegated | MCO is required to perform an annual oversight delegation audit of encounter data reporting/ claims processing.  The objective of this audit is to assess the effectiveness of key internal controls by ensuring the accuracy, completeness, and timeliness of the encounter/claims processing functions.  BHASO will provide MCO claims data set for specified time period. | Annual | MCO will review the claims data set for the following:  • Review encounter/claims universe sample of all claims paid or denied for 1 year;  • Verify the member was eligible for benefits on the dates of service;  • Review encounter submission and reconciliation to ensure requirements are met;  • Review claim payment calculations and verify that claims were paid accurately;  • Verify claims were submitted by the provider within 365 days of dates of service;  •Review responses to audit questionnaire to ensure compliance. |

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| Signature | Date | Signature | Date |