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OPERATIONS/READINESS REVIEW OF MECKLINK BEHAVIORAL HEALTHCARE

NORTH CAROLINA
DIVISION OF MEDICAL ASSISTANCE

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Government Human Services Consulting

MARSH & McLENNAN COMPANIES

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Introduction

Purpose

This report summarizes the findings of the 60-day pre-implementation readiness review of MeckLINK Behavioral Healthcare (MeckLINK), a local management entity (LME) in North Carolina that is implementing a prepaid inpatient health plan (PIHP) with a target date of February 1, 2013. MeckLINK was selected by the State of North Carolina (State), Department of Health and Human Services (DHHS), as a successful applicant for the Centers for Medicare & Medicaid Services (CMS) Section 1915(b)(c) waiver expansion.

The Division of Medical Assistance (DMA), representatives of the intra-departmental monitoring team (IMT) and Mercer Government Human Services Consulting (Mercer) conducted a previous onsite readiness review of MeckLINK on August 28, 2012. This report details findings from the 60-day pre-implementation review that took place November 29, 2012 to assess overall implementation readiness.

Background

LMEs bidding on the PIHP must fully prepare their systems, staff and processes to implement the program, consistent with CMS requirements and State criteria, which is listed in Appendix A. DHHS also requires the implementing LMEs to adopt a set of policies and procedures (P&Ps) developed by Cardinal Innovations (CI), the first PIHP in North Carolina. Cardinal Innovations, in collaboration with the IMT, has designed effective P&Ps during the past several years. Thus, DHHS wants to ensure statewide consistency of P&Ps while also addressing local needs.

The DHHS DMA contracts with Mercer to assist the IMT in its oversight of the PIHP implementation process. The IMT includes representatives from DMA and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS). As part of its oversight, the IMT conducts readiness reviews. Mercer provides technical assistance to the IMT on readiness milestones and prepares the readiness review reports.

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Readiness Status for February 1, 2013 Implementation

This section of the report highlights the key findings and recommendations. MeckLINK has made noteworthy progress since the last readiness review. Examples of accomplishments since the previous review include progress with hiring staff, AlphaMCS client information system development, use of consultants with managed care experience, hiring of a waiver project manager and achievement of URAC accreditation. Despite significant advances, critical tasks necessary to successfully implement the waiver are still outstanding and it will be challenging to resolve all identified concerns prior to the targeted implementation date. Mercer believes that diligent oversight must occur (i.e., weekly detailed status updates) and evidence of successful completion of critical tasks must be closely monitored for MeckLINK to achieve waiver readiness within the established timeline.

Key Findings and Recommendations

The following tables outline key findings and recommendations.

Findings	Recommendations
Customer Services	
• The MeckLINK call center includes the following functions: member enrollment and eligibility; screening, triage and referral and customer service. The call center includes intake specialists (non-licensed, respond to all initial calls); case coordinators (qualified professionals, process service referrals); intellectual developmental disabilities (I/DD) case coordinators (maintain registry of unmet needs, respond to requests for I/DD services); and care managers (licensed, conduct pre-certification of inpatient level of care, complete service referrals, and conduct emergent and urgent clinical triage). Current staffing vacancies include two care managers (after hours) and one I/DD case coordinator. MeckLINK is currently using the adjacent hospital to handle after-hours calls and plans to offer 24/7 call response on January 1, 2013.	• Complete hiring and training of customer service staff. Begin 24/7 call center operations as soon as feasible.

Findings	Recommendations
Customer Services	
• The flow chart for triaging I/DD emergent and urgent calls does not reflect reported practice.	• Ensure that all customer service policies, procedures and flow charts represent current call center practices. I/DD recipients should be able to access crisis or other community supports as clinically indicated and consistent with other disability populations covered under the waiver.
• In the event of an emergency call, the responding intake specialist can instant message a clinician or activate a bell to alert clinicians to report to the intake specialist's desk to assist with call handling and clinical triage. The licensed individual will either accept the call via warm transfer or will take the call at the responding intake specialist's desk.	• Reassess the feasibility of the process to alert clinicians to respond to an emergency call given the expected increase in call volume post waiver implementation and the possibility that it will be necessary to respond to multiple emergency calls simultaneously.
• Call center staff can conduct member searches in AlphaMCS to determine if the member is already enrolled; can identify providers involved with the member and the name of any assigned care coordinator; can conduct provider searches and schedule service appointments with providers via the AlphaMCS; and can warm transfer members to the assigned provider. Additionally, the system has capacity for the provider to document the appointment disposition.	• None.
• The MeckLINK home page currently has multiple telephone numbers listed for customer service, contacting the call center and filing complaints.	• Review and revise the MeckLINK home page to ensure that waiver participants can clearly discern a single telephone number for contacting the call center and initiating a referral for services.
• MeckLINK has developed a disaster recovery plan and will utilize the adjacent hospital or a subcontracted vendor to assist with call center operations in the event of an outage. Some aspects of the disaster recovery plan have been tested.	• MeckLINK should ensure that all components of the disaster recovery plan are fully tested prior to waiver implementation.
• MeckLINK is currently in the process of developing a provider help desk. Claims issues can be handled by call center intake specialists with capacity to refer to a designated person within the claims department if unable to resolve.	• MeckLINK should ensure that claims related issues are not routed to a single designated person within the claims department as this will not be feasible given the expected volume of provider claims inquiries post waiver implementation.

Findings	Recommendations
Customer Services	
• MeckLINK provides oversight of call center staff and functions via clinical supervision, live call monitoring, recorded call monitoring and "secret shopper" studies conducted by local consumer and family advisory committee members.	• None.
• MeckLINK's call center handled 2,914 calls during quarter one of fiscal year (Q1FY) 2013. MeckLINK is anticipating a 30%-50% increase in call volume post waiver implementation. The current customer service organizational chart includes a relatively small number of intake specialists (initial call responders) and a significantly larger contingent of licensed clinicians (involved with clinical screening, triage and referral).	• Reassess the planned staffing model for the customer service department. It may be necessary to designate additional intake specialists to handle the expected call volume.
• MeckLINK is not currently tracking or analyzing the ratio of calls that require clinical triage versus those that are informational in nature.	• MeckLINK should track and analyze the types and nature of calls handled by the call center to assist with the assessment of call center staffing patterns.
• The Cisco call center system currently produces call center statistics. Other customer service management reports are currently in development.	• Finalize identification, development, testing and production of customer service management reports.
• MeckLINK is currently considering two options to assist with call center overflow; subcontract with a local LME/PIHP or utilize Protocol.	• MeckLINK needs to expedite decisions and subcontracts related to support for potential call center overflow.

Findings	Recommendations
Clinical Care Management/Utilization Review (CM/UR)	
• Care coordination staff will be co-located across four district offices within the geographic service area. 95% of care coordination staff has been hired and vacancies that currently exist are characterized as "non-critical" for waiver implementation.	• None.
• Mental health/substance abuse (MH/SA) clinical care coordinators will have specialty area expertise, such as adults, children and geriatrics as well as Community Care of North Carolina specialists, housing specialists, state hospital liaisons and forensics.	• None.
• All care coordination P&Ps are reported to be complete.	• None.

Findings	Recommendations
Clinical Care Management/Utilization Review (CM/UR)	
• MeckLINK has developed care coordination admission and discharge criteria and intensity of need ratings which have been incorporated into AlphaMCS.	• None.
• Under the direction of the medical director, MeckLINK makes clinical supervision available to all care coordination and CM/UR staff via daily and ad hoc staffings, 1:1 supervision every other week, and access to clinical consultation through use of technology (SMART boards, teleconferencing). A subcontracted vendor (Prest) will provide clinical support services.	• None.
• All care coordination referrals, including referrals generated internally will be routed through the MeckLINK call center for tracking purposes. Only call center staff can currently complete care coordination referral documentation to support unified tracking.	• To enhance work flow efficiencies, MeckLINK should consider allowing care coordinators and other clinical staff within the organization to document care coordination referral information for tracking purposes.
• MeckLINK care coordination managers and supervisors assign caseloads to staff and have access to reports to assess caseload size across care coordinators. The determination that a member meets criteria for care coordination and the intensity of need levels are assigned during a daily staffing.	• None.
• While some reports (caseload report) are available to support the care coordination and CM functions, many care coordination and CM/UR management reports are still in various stages of development.	• Finalize identification, development, testing, and production of care coordination and CM/UR management reports.
• MeckLINK has conducted provider trainings (including technical assistance to hospital provider groups) regarding the process to submit, revise and review service authorization requests.	• None.
• MeckLINK has initiated a process for care coordinators and care managers to identify and refer potential quality of care (QOC) issues for review and investigation, although this process has not been formalized.	• MeckLINK should formalize the process to identify and refer QOC issues and provider performance concerns. A QOC trigger list may be helpful with this process. Issues should be tracked and trended to identify opportunities for systemic improvement.

Findings	Recommendations
Clinical Care Management/Utilization Review (CM/UR)	
• Cases are randomly assigned to available care managers based on MH/SA or I/DD and may not stay with the same care manager over time.	• MeckLINK should consider assignment of the same care manager across episodes of care when feasible, as this can promote more active care management.
• Denial documentation can be inputted by MeckLINK clinical peer reviewers and processed within AlphaMCS, but grammatical issues with appeal notice letter templates persist. Prest (subcontracted clinical peer review service provider) produces a denial report which is subsequently copied and pasted into AlphaMCS.	• Fully resolve appeal notice letter template issues prior to waiver implementation.
• ValueOptions (VO) authorization data have not been received to date. An assessment in August 2012 projected volume to be approximately 56,000 authorizations.	• MeckLINK should consider updating projections of the volume of VO authorization data to assist with the assessment and designation of CM/UR staffing resources.
• MeckLINK conducts inter-rater reliability (IRR) testing with CM/UR staff on a quarterly basis and has established a performance threshold of 80%. Clinical supervision occurs with individuals who fail to achieve the minimum performance threshold.	• MeckLINK should consider sharing IRR testing results with all participating CM/UR staff to leverage opportunities for continuous quality improvement.
• MeckLINK is currently developing service definitions and clinical guidelines/decision support tools and loading into AlphaMCS.	• MeckLINK should ensure that service definitions and clinical guidelines/decision support tools are available to CM/UR staff via AlphaMCS.

Findings	Recommendations
Network Operations/Provider Relations	
• At the time of the onsite review, the following information was reported regarding MeckLINK's provider network development efforts: — Licensed independent practitioners (LIPs) – 873 applications received; 0 credentialed; 0 contracted — Agencies – 198 applications received; 33 credentialed; 33 contracted — Group practices – 175 applications received; one credentialed; 0 contracted; and — Hospitals – 23 applications received; 2 credentialed; 0 contracted.	• Complete provider credentialing, contracting and loading of data into the client information system to support the authorization of covered services and claims processing.

Findings	Recommendations
Network Operations/Provider Relations	
• MeckLINK has analyzed paid claims data and compared against provider applications received to date to support the outreach and engagement of high volume providers within the geographic service area.	• MeckLINK should continue efforts to develop a comprehensive provider network by tracking executed contracts against known high volume providers in the geographic service area.
• MeckLINK has subcontracted with Medversant to assist with credentialing (primary source verification activities) LIPs and hospitals including collecting applications and required documents.	• Continue to assess and deploy necessary resources to complete credentialing, contracting and loading of data into client information system prior to waiver implementation.
• MeckLINK is expecting to finalize all network operations hiring by January 9, 2013.	• Complete hiring and training of network operations staff.
• The network operations department has requested reports that are available via AlphaMCS, but currently lack the capability to run and produce ad hoc reports.	• Finalize identification, development, testing and production of network operation's management reports.

Findings	Recommendations
Quality Assurance and Quality Improvement (QI)	
• MeckLINK achieved URAC accreditation in the areas of call center, utilization management and network in September 2012.	• None.
• The quality management department has hired four of seven full-time employees. Vacancies at the time of the review include a QI analyst, clinical risk manager and an appeals coordinator.	• Complete hiring and training of quality management staff.
• MeckLINK is not anticipating a large increase in appeal volume post waiver implementation. The assessment is based on historic integrated payment and reporting system funded service denials and information from other PIHPs that have implemented the waiver.	• Appeals volume may be larger than anticipated post waiver implementation based on experience of other PIHPs. MeckLINK should continue to assess appeal volume closely and ensure appropriate contingency plans are in place and ready for implementation if necessary.
• The MeckLINK quality management department is responsible for producing dashboards and has assigned quality analysts to different organizational functional areas to support agency wide reporting. Other report development and testing responsibilities rest with the information technology (IT) department.	• MeckLINK should develop an organized approach regarding report identification, prioritization, development and implementation. Once the critical waiver management reports are available, there should be a process, structure and staffing to review the data and take appropriate actions in response to the information.

Findings	Recommendations
Financial Management/Monitoring	
• At the time of the review, MeckLINK did not have a chief financial officer.	• MeckLINK had an offer out to an individual at the time of the review. Finalize the offer of employment to the individual or persist in the recruitment of another qualified individual to ensure proper oversight of the financial activities of the plan.
• Program integrity/fraud and abuse is to be subcontracted to an outside vendor. However, the contract has not been finalized, P&Ps do not exist, MeckLINK does not have a telephone number or web application setup or have a plan to setup for reporting fraud and abuse.	• Establish the program integrity department by: — Finalizing the contract for the program integrity staff — Developing P&Ps — Setting up a dedicated telephone line and web application for reporting fraud and abuse — Posting the fraud and abuse contact information on the website — Developing tools to track fraud and abuse cases, status and resolution information.
• There is no process in place for tracking a refund check received from a provider from the Advantage general ledger system back through the AlphaMCS claims system to ensure accurate application of the funds received.	• Accounting and claims staff need to develop an operational process that will provide accurate tracking of a refund check received from the provider from the Advantage system to the AlphaMCS system and the 835 transaction reporting.
• P&Ps have not been developed for many processes specific to Medicaid. These include but are not limited to: — Payments for out of network providers including sending of paper remittance advice — Risk reserve fund — IBNR liability — Third party liability — Fraud and abuse.	• Develop policies with detailed procedures for the Medicaid program for processes related to the Finance department.

Findings	Recommendations
Financial Management/Monitoring	
• IBNR methodology has not been developed for the Medicaid program.	• IBNR methodology needs to be developed and documented in detail to include data sources both before and after the availability of MeckLINK paid claims data. This may include the use of prior authorizations, historical claims information provided by the State, claims information from AlphaMCS such as the claims lag report, etc.
• Processes to reconcile the AlphaMCS claim data, the Advantage general ledger, the report server and business objects/data warehouse data have not been tested to ensure the data are accurate and agrees across all systems.	• Implement processes to reconcile all data including financial information, in the databases of the AlphaMCS, Advantage, the report server and business objects/data warehouse. This process must be thoroughly tested and documented to include control total checks such as record counts, dollar amounts and other fields as determined necessary. Currently, certain procedures will create discrepancies in systems and reports (i.e., not sending all processed claims from AlphaMCS to Advantage).
• The risk reserve fund required by the State has not been established nor has a policy for maintenance been developed.	• A risk reserve fund needs to be established as required by the State along with appropriate P&P documentation for maintaining the required balance.
• The capitation reconciliation policy refers mainly to the process of reconciling the eligibility files rather than the capitation file to the members eligible for Medicaid services.	• Separate policies should exist for reconciling the Health Insurance Portability and Accountability Act (HIPAA) 820 capitation file to the system and the amount of funds actually received, and for reconciling the HIPAA 834 eligibility file received with eligible members per the system and performing additional data checks using the HIPAA 270/271 transactions.

Findings	Recommendations
Staffing and Facilities	
• There appears to be overstaffing in many departments.	• With an expected high auto adjudication rate in the AlphaMCS system, the claims department appears to be overstaffed for the number of claims that would be processed on a daily basis. Additional review of departmental needs prior to hiring additional full-time staff should be performed.

Findings	Recommendations
Staffing and Facilities	
• MeckLINK is renovating a new location for the corporate staff in Charlotte. The plan is to move in the first part of February which coincides with the implementation of the waiver.	• Evaluate the timing of the move of the corporate office to a new location at the same time as implementing the Medicaid waiver. This could cause additional disruption to staff and service delivery.

Findings	Recommendations
Claims and IT	
• AlphaMCS claims system configuration testing for waiver services is incomplete. Robust testing needs to confirm accuracy of provider configuration, fee schedules, pricing, remittance advice and all system edits.	• Thorough testing of the AlphaMCS system needs to continue to verify the system is set-up accurately for proper edit application and claims payment. This included scenarios for each system edit, claim appeals/adjustments, coordination of benefits, inpatient, emergency department, out of network providers, etc.
• MeckLINK has begun formal testing of professional claims functions with providers; however, no institutional provider testing has been performed, nor has end-to-end testing been performed for electronic submissions.	• Perform content testing of electronic claim submission with providers, for both professional and institutional claims, to ensure that claims load properly and can process through the system edits.
• Medicaid provider training on the system has just started at MeckLINK. Some providers may already be trained due to other PIHPs using the AlphaMCS system. MeckLINK did not have an internal communication process to determine which providers are trained or do not need additional system training but need to have system access established. MeckLINK had discussion about having the network department set up the provider log-in which should not be possible for security purposes.	• Communication needs to be improved between the network department and IT to ensure all providers are trained and have access to the AlphaMCS system for authorizations and claims processing functions. Providers need to be identified if they are currently using the AlphaMCS system with other entities as they should not be required to participate in MeckLINK AlphaMCS training. These providers need to be linked to MeckLINK in the system so their current ID and password can access necessary MeckLINK Medicaid recipients.

Findings	Recommendations
Claims and IT	
• The transfer of data between AlphaMCS and Advantage requires manual processes to scan AlphaMCS reports to upload supporting documentation in Advantage. These processes seem to be redundant as AlphaMCS already contains information that is sufficient to provide proof of payment should auditors or other regulatory bodies request/require it. While the current plan includes automating the process at some future date, it is still an additional step necessary before payment can be made to the provider.	• MeckLINK and the County should review the County requirements for scanning of supporting documentation for claims payments. MeckLINK should thoroughly review the processes in place once a claims batch has been approved for payment. With a greater quantity of providers for the Medicaid business that may be receiving weekly checks, these manual steps may delay provider payments and denial notification.
• P&P development has not been finalized. Many P&Ps have not been finalized or lack detailed procedures. This includes but is not limited to: — P&P for producing a paper remittance advice for those providers requiring manual checks.	• Develop detailed procedures for all policies. This may be part of the claims system manual, but should be referenced in the P&P.
• Claims payment processes for when check write will occur have not been determined. MeckLINK indicated that they may go to daily check writes.	• Develop check write schedule and processes that need to occur to follow the schedule. Check writes more frequently than weekly may be challenging for resources and timely completion of all steps of the process. Post the check write schedule on the website for providers to see.
• MeckLINK has hired a consultant to perform a HIPAA analysis to ensure HIPAA security.	• Complete the HIPAA review to ensure data security and privacy training is complete.

Findings	Recommendations
Reporting	
• Report identification is not clear on the most reports. Report names and when the report was run was not indicated and there was no clear indication of what the report contained.	• Reports need to be clearly identified as to the reporting period, date of payment or date of service, legend of the funding source, etc. Management reports/dashboards should be clearly defined with standardized headers.

Findings	Recommendations
Reporting	
• Medicaid reports for claims are in different stages (i.e., developed and tested; not started).	• Testing needs to continue and include complete validation of the data along with the report's ability to meet the user's needs. Different reports of the same data must be able to report the same information (i.e., provider versus procedure codes). Ensure these reports provide MeckLINK the ability to operate as a PIHP at "go-live". This includes identification of key financial and clinical reports to identify areas of concern. The management team should discuss the reports to direct change and ensure continued fiscal solvency of the PIHP.
• State required financial reports have not been developed.	• State required reporting needs to be developed, tested and completed to include, but not limited to balance sheet and income statement reporting by category of aid where required, as well as all other financial reports. Testing of these reports needs to include complete validation of the data. Reporting on data from different sources (Advantage, AlphaMCS, data warehouse, reporting server) must be able to report the same end results (i.e., totals). Specifically need to ensure the ability to accurately produce reports by category of aid out of the various sources that agree overall to the summary level in the Advantage system.
• Some financial reports are developed by the IT department vs. by the finance department. At the time of the review, the finance department was not aware of their responsibility to validate these reports.	• Financial reporting developed by the IT department must be tested to validate the results and ensure the reports are providing the expected information.
• Report scheduling has not been set up.	• Report scheduling should be set up so that efficiency can be gained after go live for staff to have necessary reports available upon arrival at work.
• Financial dashboards have not been developed.	• Financial dashboards need to be developed, tested and completed. Dashboards will provide immediate drill down capabilities in the reports and provide valuable information with which to oversee the results of the plan.

Findings	Recommendations
Reporting	
• Staff with the current capability to run reports seemed to be limited. Since many reports have not been developed, additional training will need to occur.	• Train appropriate departmental staff on how to access and run reports to manage business operations.

APPENDIX A

LME PIHP Criteria

1. A proven track record with demonstrated success in operating as a LME, as defined in North Carolina General Statues §122C-116.

2. Demonstrated capacity to operate a managed care program, as exemplified by:

   - Financial and risk management resources to ensure that liquidity and solvency requirements are met.

   - Flexible financial analysis and monitoring tools to identify service utilization and costs in a timely manner.

   - The ability to grow equity and capital resources while providing extended behavioral health benefits to State and county populations.

   - The ability to identify third party resources to ensure that Medicaid is the payer of last resort.

   - Effective fraud and abuse policies and detection mechanisms.

   - A cohesive management structure that meets the requirements to contract with the State.

   - A flexible, responsive customer services approach that is highly ingrained in the organization and that promotes 24-hour access to services.

   - Access to industry standard tools, technology and expertise in MH/DD/SAS.

   - A CM/UR program that is person-centered, emphasizes the principles of recovery, resilience and self-determination and relies on state-of-the-art utilization management protocols and clinical practice guidelines.

   - A well-developed quality management program that has sufficient clinical and technical leadership and data management capabilities to monitor and improve access, quality and efficiency of care.

- A provider network management program that facilitates the development, support and monitoring of network providers for the delivery of MH, DD and SAS provided to children, youth, families and adults.

- Experience and demonstrated success in implementing program innovations that result in improved administrative and clinical outcomes, such as increased access to care by traditionally underserved populations of all ages, improved community tenure, MH/DD/SAS-physical health integration and integrated assessment and service delivery for both co-occurring mental illness and substance use disorders and co-occurring mental illness and DD.

- Human resource and management support necessary to effectively recruit and retain clinical and administrative qualified professional staff.

- A solvent and financially viable organization that has sufficient financial and administrative resources to implement and operate managed care functions specified in the request for application (RFA).

- An automated management information system that is capable of performing all the activity, interfacing and reporting requirements (utilizing electronic data interchange) using HIPAA transactions.

3. Demonstrated capacity and a proven approach to managing systems of care that:

   - Rely on innovative approaches to address the diversity and cultures of the population served, including, at a minimum, contracts with culturally competent providers.

   - Identify and implement the preferences of individuals and families in the design of services and supports through development and utilization of person-centered planning.

   - Facilitate the development of consumer-operated programs and use of peer support, including consumer/family team approaches.

   - Facilitate the development and utilization of natural supports.

   - Facilitate the use of self-management and relapse prevention skills, support stable housing and address the development and maintenance of healthy social networks and skills, employment, school performance or retirement activities.

4. Demonstrated capacity to implement the requirements specified in this RFA through a well-designed and detailed implementation plan that clearly articulates tasks, timeframes and expected results.

APPENDIX B

MeckLINK Plan of Development

The tasks below are considered vital for MeckLINK to address to successfully implement the waiver. Each task must be accomplished before the go-live date in order to help assure a smooth transition as a PIHP.

MeckLINK Plan of Development
Customer Services
• Complete hiring and training of customer service staff. Begin 24/7 call center operations as soon as feasible. • Ensure that all customer service policies, procedures and flow charts represent current call center practices. I/DD recipients should be able to access crisis or other community supports as clinically indicated and consistent with other disability populations covered under the waiver. • Reassess the feasibility of the process to alert clinicians to respond to an emergency call given the expected increase in call volume post waiver implementation and the possibility that it will be necessary to respond to multiple emergency calls simultaneously. • Review and revise the MeckLINK home page to ensure that waiver participants can clearly discern a single telephone number for contacting the call center and initiating a referral for services. • MeckLINK should ensure that all components of the disaster recovery plan are fully tested prior to waiver implementation. • MeckLINK should ensure that claims related issues are not routed to a single designated person within the claims department as this will not be feasible given the expected volume of provider claims inquiries post waiver implementation. • Finalize identification, development, testing and production of customer service management reports. • MeckLINK needs to expedite decisions and subcontracts related to support for potential call center overflow.
Clinical CM/UR
• Finalize identification, development, testing, and production of care coordination and CM/UR management reports. • MeckLINK should formalize the process to identify and refer QOC issues and provider performance concerns. A QOC trigger list may be helpful with this process. Issues should be tracked and trended to identify opportunities for systemic improvement.
Network Operations/Provider Relations
• Complete provider credentialing, contracting and loading of data into the client information system to support the authorization of covered services and claims processing. • Continue to assess and deploy necessary resources to complete credentialing, contracting and loading of data into client information system prior to waiver implementation.

MeckLINK Plan of Development
• Complete hiring and training of network operations staff. • Finalize identification, development, testing and production of network operation's management reports.
Quality Assurance and QI
• Complete hiring and training of quality management staff. • MeckLINK should develop an organized approach regarding report identification, prioritization, development and implementation. Once the critical waiver management reports are available, there should be a process, structure and staffing to review the data and take appropriate actions in response to the information.
Financial Management/Monitoring
• MeckLINK had an offer out to an individual at the time of the review. Finalize the offer of employment to the individual or persist in the recruitment of another qualified individual to ensure proper oversight of the financial activities of the plan. • Establish the program integrity department by: — Finalizing the contract for the program integrity staff — Developing P&Ps — Setting up a dedicated telephone line and web application for reporting fraud and abuse — Posting the fraud and abuse contact information on the website — Developing tools to track fraud and abuse cases, status and resolution information • Develop policies with detailed procedures for the Medicaid program for processes related to the Finance department. • IBNR methodology needs to be developed and documented in detail to include data sources both before and after the availability of MeckLINK paid claims data. This may include the use of prior authorizations, historical claims information provided by the State, claims information from AlphaMCS such as the claims lag report, etc. • Implement processes to reconcile all data including financial information, in the databases of the AlphaMCS, Advantage, the report server and business objects/data warehouse. This process must be thoroughly tested and documented to include control total checks such as record counts, dollar amounts and other fields as determined necessary. Currently, certain procedures will create discrepancies in systems and reports (i.e., not sending all processed claims from AlphaMCS to Advantage). • A risk reserve fund needs to be established as required by the State along with appropriate P&P documentation for maintaining the required balance. • Separate policies should exist for reconciling the Health Insurance Portability and Accountability Act (HIPAA) 820 capitation file to the system and the amount of funds actually received, and for reconciling the HIPAA 834 eligibility file received with eligible members per the system and performing additional data checks using the HIPAA 270/271 transactions.
Staffing and Facilities
• With an expected high auto adjudication rate in the AlphaMCS system, the claims department appears to be overstaffed for the number of claims that would be processed on a daily basis.

MeckLINK Plan of Development
Additional review of departmental needs prior to hiring additional full-time staff should be performed. • Evaluate the timing of the move of the corporate office to a new location at the same time as implementing the Medicaid waiver. This could cause additional disruption to staff and service delivery.
Claims and IT • Thorough testing of the AlphaMCS system needs to continue to verify the system is set-up accurately for proper edit application and claims payment. This included scenarios for each system edit, claim appeals/adjustments, coordination of benefits, inpatient, emergency department, out of network providers, etc. • Perform content testing of electronic claim submission with providers, for both professional and Complete the HIPAA review to ensure data security and privacy training is complete.institutional claims, to ensure that claims load properly and can process through the system edits. • Communication needs to be improved between the network department and IT to ensure all providers are trained and have access to the AlphaMCS system for authorizations and claims processing functions. Providers need to be identified if they are currently using the AlphaMCS system with other entities as they should not be required to participate in MeckLINK AlphaMCS training. These providers need to be linked to MeckLINK in the system so their current ID and password can access necessary MeckLINK Medicaid recipients. • Develop detailed procedures for all policies. This may be part of the claims system manual, but should be referenced in the P&P. • Complete the HIPAA review to ensure data security and privacy training is complete.
Reporting • Reports need to be clearly identified as to the reporting period, date of payment or date of service, legend of the funding source, etc. Management reports/dashboards should be clearly defined with standardized headers. • Testing needs to continue and include complete validation of the data along with the report's ability to meet the user's needs. Different reports of the same data must be able to report the same information (i.e., provider versus procedure codes). Ensure these reports provide MeckLINK the ability to operate as a PIHP at "go-live". This includes identification of key financial and clinical reports to identify areas of concern. The management team should discuss the reports to direct change and ensure continued fiscal solvency of the PIHP. • State required reporting needs to be developed, tested and completed to include, but not limited to balance sheet and income statement reporting by category of aid where required, as well as all other financial reports. Testing of these reports needs to include complete validation of the data. Reporting on data from different sources (Advantage, AlphaMCS, data warehouse, reporting server) must be able to report the same end results (i.e., totals). Specifically need to ensure the ability to accurately produce reports by category of aid out of the various sources that agree overall to the summary level in the Advantage system. • Financial reporting developed by the IT department must be tested to validate the results and ensure the reports are providing the expected information. • Train appropriate departmental staff on how to access and run reports to manage business operations.

The tasks below are important operational issues, but not considered as essential and critical for successful implementation of the waiver. The tasks below should be completed as soon as practical following the implementation of the waiver.

MeckLINK Plan of Development
Customer Services
• Reassess the planned staffing model for the customer service department. It may be necessary to designate additional intake specialists to handle the expected call volume. • MeckLINK should track and analyze the types and nature of calls handled by the call center to assist with the assessment of call center staffing patterns.
Clinical CM/UR
• To enhance work flow efficiencies, MeckLINK should consider allowing care coordinators and other clinical staff within the organization to document care coordination referral information for tracking purposes. • MeckLINK should consider assignment of the same care manager across episodes of care when feasible, as this can promote more active care management. • Fully resolve appeal notice letter template issues prior to waiver implementation. • MeckLINK should consider updating projections of the volume of VO authorization data to assist with the assessment and designation of CM/UR staffing resources. • MeckLINK should consider sharing IRR testing results with all participating CM/UR staff to leverage opportunities for continuous quality improvement. • MeckLINK should ensure that service definitions and clinical guidelines/decision support tools are available to CM/UR staff via AlphaMCS.
Network Operations/Provider Relations
• MeckLINK should continue efforts to develop a comprehensive provider network by tracking executed contracts against known high volume providers in the geographic service area.
Quality Assurance and QI
• Appeals volume may be larger than anticipated post waiver implementation based on experience of other PIHPs. MeckLINK should continue to assess appeal volume closely and ensure appropriate contingency plans are in place and ready for implementation if necessary.
Financial Management/Monitoring
• Accounting and claims staff need to develop an operational process that will provide accurate tracking of a refund check received from the provider from the Advantage system to the AlphaMCS system and the 835 transaction reporting.
Claims and IT
• MeckLINK and the County should review the County requirements for scanning of supporting documentation for claims payments. MeckLINK should thoroughly review the processes in place once a claims batch has been approved for payment. With a greater quantity of providers for the Medicaid business that may be receiving weekly checks, these manual steps may delay provider payments and denial notification. • Develop check write schedule and processes that need to occur to follow the schedule. Check writes

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more frequently than weekly may be challenging for resources and timely completion of all steps of the process. Post the check write schedule on the website for providers to see.
Reporting • Report scheduling should be set up so that efficiency can be gained after go live for staff to have necessary reports available upon arrival at work. • Financial dashboards need to be developed, tested and completed. Dashboards will provide immediate drill down capabilities in the reports and provide valuable information with which to oversee the results of the plan.

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