

Information System Capabilities Assessment (ISCA)

Information System Capabilities Assessment (ISCA) For Managed Care Organizations/Prepaid Health Plans

I. GENERAL INFORMATION

Please provide the following general information:

Note: The information requested below pertains to the collection and processing of data for an MCO/PIHP's Medicaid line of business. In many situations, if not most, this may be no different than how an MCO/PIHP 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/PIHP identification information below, including the MCO/PIHP name, MCO/PIHP contact name and title, mailing address, telephone and fax numbers, and E-mail address, if applicable.

MCO/PIHP 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: 2003	Year: 2004	Year: 2005
Privately Insured			
Medicare			
Medicaid			
Other			

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

Circle a response: Yes No

If yes, who performed the assessment? _____

When was the assessment completed? _____

NOTE: If your MCO/PIHP'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.

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II. 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 | E. Network |
| B. Hierarchical | F. Flat File |
| C. Indexed | G. Proprietary |
| D. 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 | E. Network |
| B. Hierarchical | F. Flat File |
| C. Indexed | G. Proprietary |
| D. Other | H. Don't Know |

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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 much resources (time, money) are spent on training per programmer per year?

What type of standard training for programmers is provided? What type of additional training is provided?

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15. Who is responsible for your organization meeting the State Medicaid reporting requirements (CEO, CFO, 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?

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

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III. 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)

B.

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
Inpatient			
Psychiatric			
ICF-MR			
Outpatient			
Community Support			
Residential			
Innovations			
Substance Abuse			
Case Management			
Other:			

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	Inpatient	Psychiatric	ICF-MR	Outpatient	Community Support	Residential	Innovations	S/A	C/M
Claims/encounters submitted electronically									
Claims/encounters submitted on paper									
Services not submitted as claims or encounters									
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%

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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	Inpatient	Psychiatric	ICF-MR	Outpatient	Community Support	Residential	Innovations	S/A	C/M
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	
	Diagnosis	Procedure	Diagnosis	Procedure
Institutional Data				
Provider/Provider				
Group Data				

5a. Can you distinguish between principal and secondary diagnoses?

Circle your response. Yes No

5b. 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 code?

Institutional Data:

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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
Inpatient		
Psychiatric		
ICF-MR		
Outpatient		

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Community Support		
Residential		
Innovations		
Substance Abuse		
Case Management		
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	Psychiatric	ICF-MR	Outpatient	Community Support	Residential	Innovations	S/A	C/M
ICD-9-CM									
CPT-4									
HCPCS									
DSM-IV									
National Drug Code									
Internally Developed									
Other (specify)									
Not required									
TOTAL									

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

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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?

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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, 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?

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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/PIHP offers additional product lines to the State; e.g., S-CHIP, partial risk products).

Systems Used to Process	Medicaid B Waiver	Medicaid C Waiver	Other
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?

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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 who 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 overrides or "exceptions" generated on each processor and reviewed by the claim supervisor? 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 (Ausual & customary)
- Bill "re-pricing" for carved out benefits (mental health, substance abuse)

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

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24g. Describe the system's editing capabilities that assure that Medicaid claims are adjudicated correctly. 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.

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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 - old system still used
- Major enhancements to old system (what kinds of enhancements?)
- New product line members stored on old system.

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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, State, commercial plan, Medicare) to another?

Circle your response. Yes No

5a. Can you track an enrollee's initial enrollment date with your MCO/PIHP 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/PIHP's information management systems? Under what circumstances, if any, can a member's identification number change?

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

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7. If your MCO/PIHP 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.

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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.

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/PIHP incorporate data from vendors to calculate any of the following Medicaid quality measures? If so, which measures require vendor data?

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NOTE: The measures listed in the following table are examples of measures that can be calculated with administrative data. The State and EQRO should tailor this table to list those measures that the State requires its MCO/PIHP contractors to produce and any other measures in which the State is interested.

See Page 64-66 of State Contract No. 00011350

MEASURE	Vendor NAME
Effectiveness of Care Measures:	
1. Percentage of discharges for Medicaid enrollees	
2. Readmission Rates for Mental Health	
3. Readmission Rates for Substance Abuse	
4. Ambulatory Follow-Up within 7 calendar days for discharge for Substance Abuse therapy	
5. Ambulatory Follow-Up within 7 calendar days of discharge for Mental Health	
6. Number of Consumers Moved from Institutional Care to Community Care	
Access/Availability Measures:	
1. The Percentage of adults diagnosed with AOD dependence who initiate treatment within 14 days	
2. Call answer Timeliness (Percentage of Member services calls answered within 30Seconds)	
3. Call Abandonment (Percentage of member services calls that were abandoned after being answered by a live voice.)	
4. Number and type of calls received and the disposition of those calls.	
5. Number and percentage of visits for services obtained but not authorized by PIHP.	
6. Number and percentage of total services that are rendered out of network?	
7. The average amount of time from C-Waiver services approval to initiation of services.	
The average amount of time from C-Waiver services approval of initiation of services to plan of service development	
The average amount of time from C-Waiver services from plan of service development to implementation of direct care services	
Patient and Provider Satisfaction:	
1. Provider Satisfaction Survey	

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2. Reporting on Complaints/Grievances/Appeals	
3. Consumer Satisfaction Survey	
Use of Services:	
1. Mental Health Inpatient utilization- Discharges and Average Length of Stays by age and sex	
2. Percentage of Members receiving Inpatient, Residential, Outpatient, and Community support services.(Service type)	
3. Chemical Dependency Utilization-Inpatient Discharges and Average Length of stays by age and sex	
4. Chemical Dependency: Percentage of members receiving services by service type	
5. The number and percentage of members with an alcohol and other drug claim, by diagnosis and type of services.	
6. Number and percentage of enrollees receiving Personal Care Services, Habilitation Services, and Respite services. Average amount of each service use per enrollee.	
Health Plan Stability:	
1. Number and type of all providers in the network by the type of service rendered	
Plan Descriptive Information:	
1. Unduplicated Count of Medicaid members	
2. Diversity of Medicaid Members	
Health and Safety:	
1. Critical Incident Reports	
2. Crisis Plans	
3.	

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.

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4. Describe the kinds of information sources available to the MCO/PIHP 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?

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D. Integration and Control of Data for Performance Measure Reporting

This section requests information on how your MCO/PIHP 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.

File Consolidation

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 27](#).
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 be 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?

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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?

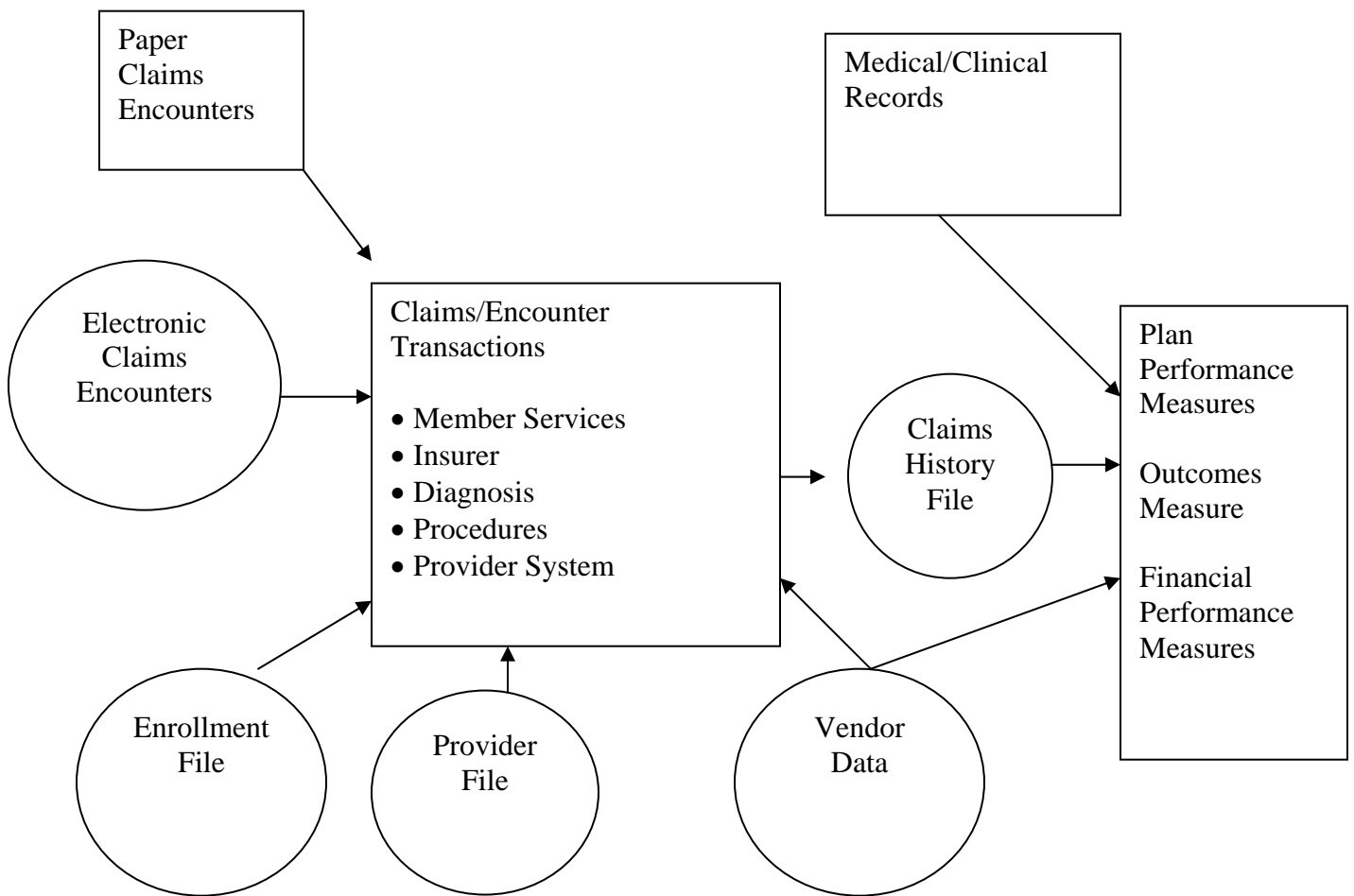
6. Are Medicaid reports created from a vendor software product? If so, how frequently are the files updated? How are reports checked for accuracy?

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

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EXAMPLE

Performance Measure Data: Flowchart of Information System Structure



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Vendor Data Integration

8. 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/PIHP 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/PIHP 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 no eligible members, please indicate "N/A."

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Medicaid Claim/Encounter Data from Vendors

Type of Delegated Services	Number of Contracted Vendors	Always receive Member-level Data form all Vendor(s) (Yes or No)	Integrate vendor Data with MCO/PIHP Administrative Data? (Yes or No)	Completeness of (A, B, or C)	Quality of Data (A, B, or C)	Rationale for Rating/ Concerns with Data Collecton
Inpatient						
Psychiatric						
ICF-MR						
Outpatient						
Community Support						
Residential						
Innovations						
Substance Abuse						
Case Management						
Other:						

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Performance Measure Repository Structure

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

9. If your MCO/PIHP 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/PIHP test the process used to create Medicaid performance measure reports?

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

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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?

IV. 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.

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9a. Does your MCO/PIHP maintain provider profiles in its IS?

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?

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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 Documents	Details
Previous Medicaid Performance Measure Audit Reports	Please attach final reports from any previous Medicaid performance measure audits in which your MCO/PIHP participated during the past two years.
Organizational Chart	Please attach an organizational chart for your MCO/PIHP. 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 <i>IS</i> . 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, 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 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