Preliminary Review:
UNISYS MMIS Contract with
Kentucky Department of Medicaid Services

RESEARCH MEMORANDUM NO. 473

LEGISLATIVE RESEARCH COMMISSION
March, 1997

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Ressearch Staff:
Hank Marks and Joseph Hood

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This report was prepared by the Legislative Research Commission and printed with state funds.

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MEMORANDUM

TO: Legislative Research Commission

FROM: Senator Joey Pendleton, Chair
Representative Jack Coleman, Co-Chair

SUBJECT: Preliminary Review: UNISYS MMIS Contract with Kentucky Department of Medicaid Services

DATE: December 10, 1996

At the September 12, 1996 meeting Program Review and Investigations Committee staff was requested by Rep. Jack Coleman to review the status of the UNISYS MMIS contract with the Department of Medicaid Services (DMS). This request was in response to concerns that Medicaid providers were not being paid for services rendered.

On November 14, 1996 the Committee heard the staff report and testimony from Department of Medicaid Services and UNISYS officials. Based on a limited review of contract performance, six findings were identified in the report. These findings focused on the assessment of financial penalties against UNISYS and the remaining outstanding contract deliverables. UNISYS responded with a presentation based on improved performance reflected in documents submitted to the committee (attached as Appendix D) of this memorandum. DMS stated that, while progress has been made, it was not yet

certain that UNISYS would be a successful contractor. However, the Administration has decided to stay with UNISYS for the two remaining years of the initial contract period.

After hearing the staff report and testimony, the Committee voted to approve the research memorandum for release. No further research was authorized. The staff report presented to the committee follows.

Preliminary Review

UNISYS Medicaid Management Information System (MMIS) Contract

Research Staff: Hank Marks and Joseph Hood

Purpose and Scope

This memo has been prepared in response to the committee's September 12, 1996, request for a status report on the implementation of the UNISYS (MMIS) contract.

Current Status Of UNISYS MMIS Contract

Briefly, the findings in this memorandum are as follows:

√ Contract implementation was delayed, causing very significant problems, especially for providers.

√ UNISYS has been assessed millions of dollars in performance penalties and may be assessed millions more.

√ There are still outstanding contract deliverables and accumulating liquidated damages.

√ DMS reduces Unisys's invoice payments by the amount of the federal match, because the MMIS has not received certification.

√ Significant progress toward contract compliance has been made, according to all parties concerned.

√ Providers vary widely regarding their level of dissatisfaction with service, with the Medical and Hospital Associations remaining the most vocal concerning their continued problems.

Program Description

Electronic Data Systems (EDS) was the fiscal agent for Medicaid in Kentucky until 1995. In January 1995 the Medicaid Management Information System (MMIS) contract was awarded to the UNISYS corporation, specifically its Healthcare Information Management division (HIM). The original required date for all operational processes to begin was December 1, 1995. However, claims processing did not begin until February 1996, and full claims processing implementation was not accomplished until May 1996. This phased-in approach created a backlog of unpaid provider claims, which at one point reached 1,000,000 claims. A highly-critical Courier-Journal editorial (May 1, 1996) ended by stating, "the Patton Administration is justified in pushing UNISYS hard to get things straightened out." Since then, DMS and the administration have worked to secure timely and correct provider payments and an overall improvement in contract compliance. This has included a consideration of the possibility of contracting with another MMIS/fiscal agent.

Report to DMS Commissioner and Governor Shows Improvement, Continued Problems

A status report was provided to the Commissioner of Medicaid Services on October 16, 1996, and to the Governor on October 17, 1996. DMS personnel reported the status of the UNISYS contract at that time as follows:

- UNISYS was unable to begin processing claims on the contract effective date of December 1, 1995, and an interim payment process was established to issue payments to providers. There is currently less than 2% remaining to be recouped from the $481,748,518.64 which was paid through this interim process.

- UNISYS began processing claims the middle of February 1996, utilizing a phased-in approach, which resulted in the processing of claims for all provider types by May 3, 1996. As a result of this phased-in approach, claim inventories in suspense reached almost 1,000,000 claims. Current suspended claims inventories were down to 97,196 by October 16, 1996.

- Provider complaint calls to the UNISYS Provider Relations Unit have been reduced during the last few months, as a result of reduced suspended claims inventories, the implementation of the claims adjustment and mass adjustment processes, and efforts to resolve discrepancies identified by DMS staff. Major complaints currently being received by UNISYS and DMS

prior authorization process and continued claims inventories.

- Each month UNISYS bills DMS for 1/12 of the first year fixed-cost contract price of $12.1 million. UNISYS has submitted **operational invoices** for December 1995 through September 1996, totaling $10,094,887.50. DMS has only paid invoices for May through September, totaling $1,813,621.88, because the Federal match and operational penalties are being withheld.

- Outstanding Deliverables:
  -The Management and Administrative Reporting System (MARS) is not completely operational.
  -DMS has not received the system documentation which is required for certification.
  -UNISYS has submitted **implementation** invoices totaling $6.5 million. DMS has only paid $1.3 million to date for implementation. The remaining invoices are being withheld because of disputed liquidated damages.

- Information from EDS to perform an independent disaster recovery test of the MMIS has been received.

UNISYS Has Generated More Than $300 Million In Performance Penalties

Contract provisions permit DMS to assess financial penalties for operational failures and for outstanding deliverables. DMS has reduced monthly operational invoices from UNISYS by several million dollars. Nearly $300 million in additional operational penalties have been calculated for overdue claims and adjustments. Finally, payments on UNISYS invoices for development and implementation have been withheld as a consequence of disputed liquidated damages for outstanding deliverables (liquidated damages will range from $2.5 to 8 million).

The current MMIS contract consists essentially of two documents: The Request for Proposal (RFP) developed by the Department of Medicaid Services (DMS) with consultative help from Maximus, and the UNISYS Response. The contract specifies services and performance in 26 separate functional areas. Each functional area, its purpose, objective, performance measurement and current status, is identified in Appendix A. Each function is listed in the Appendix according to the MMIS sub-system category with which DMS associates the function. These MMIS subsystems and their status are summarized in the table below:

TABLE 1

MMIS SUBSYSTEMS STATUS

SUBSYSTEM	STATUS
Recipient (e.g., recipient identification, eligibility, eligibility confirmation)	Operational
Provider (maintains comprehensive information about providers)	Operational
Third Party Liability (processes for identifying and getting other parties to pay)	Operational
Claims (12 separate functions; by far the largest sub-system)	Operational
Reference (reference information for other functions; coding, price verification)	Operational
Reporting (e.g., reporting for KenPAC, MARS, Retrospective Drug Utilization Review)	Partly Operational
SURS (Surveillance and Utilization Review; data analysis to determine program misuse)	Operational
Stand alone Functions (Ad-Hoc Reporting and Decision Support; Integrated Test Facility)	Partly Operational

Under the terms of the contract the Department for Medicaid Services can assess "liquidated damages" for failure to meet specific contract performance requirements and deliverables. Each month the Director of the Division of Administration and Development transmits a memorandum to the Account Manager of the Kentucky MMIS (UNISYS) which calculates the penalties for performance failures in various categories. For the period February to May 1996, penalties were assessed in five categories and totaled $346,700. For the period June to September, penalties were assessed in six categories and the total was $1,023,900. The eight-month total in these six categories was $1,370,600. Table 2 represents these penalties by category and month. The monthly penalties do not always relate directly to monthly volume and performance failures, and the table cannot be used to accurately track increases or declines in frequency.

A seventh category ($1 per day for claims and adjustments not processed timely) was calculated by the DMS on October 25, 1996, and those potential assessments are shown in Table 3. DMS has informed UNISYS that it will not now assess these penalties, but retains the right to do so. These penalties amount to $297,545,518. When combined with penalties in the other six categories for the past eight months, this total is $298,916,118 for the period

February to September 1996. To this total, another $2.5 million to $8 million in disputed liquidated damages may be added for outstanding deliverables (e.g., MARS, documentation needed for federal certification).

UNISYS Reports Meeting Performance Requirements in Most Areas, Improving in Others

UNISYS is currently processing approximately 2.3 million claims per month. In response to inquires from Program Review staff, UNISYS personnel provided graphs of its operational status as of November 6, 1996. These graphs (Appendix B) cover four performance areas for June through early November 1996. The first three graphs, Prior Authorization Service Level, Provider Inquiry Service Level, and Data Entry, indicate that these services are currently meeting the performance requirements of the contract.

The fourth graph, Suspended Claims Inventory, shows a declining number of suspended claims for each month of the six-month period. These claims are all claims in process that can not be immediately adjudicated. Claims that have been paid or denied are not in process, even if they are returned to the provider for further information. UNISYS Management stated that 83,618 documents (14,180 of them over 30 days) are currently suspended; down from about 280,000 in June. UNISYS noted to staff that in April about three months of claims were entered, causing a bubble in the number of claims suspended in June and July.

TABLE 3
PENALTIES FOR TIMELINES OF CLAIMS AND ADJUSTMENTS PROCESSING

DATE	CLAIMS*	ADJUSTMENTS*
February 1996	$3,251,366	
March 1996	$82,821,551	$1500
April 1996	$121,187,225	$136
May 1996	$14,496,189	$7,060
June 1996	$18,999,011	$1,170,765
July 1996	$18,333,669	$2,485,188
August 1996	$15,100,327	$4,812,659
September	$13,156,514	$1,722,358
TOTAL	**$287,345,852**	**$10,199,666**

SOURCE: DMS memoranda of October 25, 1996

***NOTE:** The RFP, Section 5.27.3, allows DMS to assess a penalty of $1.00 per day for each claim or adjustment which fails to meet the federal requirements of 30 days for timeliness of processing.

TABLE 2
ASSESSED PENALTIES, FEBRUARY TO SEPTEMBER, 1996

REQUIREMENT	FEBRUARY	MARCH	APRIL	MAY	TOTAL
1	$25,500	$45,000	$37,500	$33,000	$141,000
2	0	0	0	$44,000	$44,000
3	$6,400	$53,000	$43,400	$6,000	$108,800
4	0	$9,500	$23,500	$18,500	$51,500
5	0	$1,000	$300	$100	$1,400.00
Monthly Totals	**$31,900**	**$108,500**	**$104,700**	**$101,600**	**$346,700**
REQUIREMENT	**JUNE**	**JULY**	**AUGUST**	**SEPT.**	**TOTAL**
1	$23,000	$24,500	$28,000	$25,000	**$100,500**
2	$3,000	$9,000	$5,000	$2,000	**$19,000**
3	$16,000	$26,400	$19,200	$24,300	**$85,900**
4	$29,000	$25,000	$21,000	$20,000	**$95,000**
5	**0**	**0**	**0**	**0**	**0**
6	$20,000	$187,500	$184,500	$331,500	**$723,500**
TOTALS	**$91,000**	**$272,400**	**$257,700**	**$402,800.00**	**$1,023,900**

SOURCE: Compiled from information contained in Department of Medicaid Services/Memoranda to UNISYS

1. Section 5.2713 ECC/ECM NETWORK - $500.00 per hour or partial hour for which ECM network is not available for access
2. Section 5.27.7 RESPONSE TIME - $1,000.00 per occurrence that on-line inquiry is not available between the hours of 7:00 AM to 6:00 PM, Eastern Time, Monday through Friday, except for Commonwealth Holidays
3. Section 5.27.5 REPORT PRODUCTION TIMELINESS AND ACCURACY - $100.00 per work day for all ad hoc reports not delivered per schedule agreed upon by DMS and UNISYS
4. Section 5.27.12 VOICE RESPONSE - $500.00 per hour that voice response is not available for access
5. Section 5.27.10 PROVIDER CHECK AND REMITTANCE ADVICE PRODUCTION AND MAILINGS - $100.00 per day that the warrant tape is not delivered by 8:00 AM on the first work day of each week
6. Section 5.27.6 SYSTEM MODIFICATIONS AND MAINTENANCE - $500.00 per work day for each modification/maintenance change order that is not operational on the date agreed upon by DMS and UNISYS

Medical and Hospital Associations Remain Dissatisfied and Frustrated

Program Review staff interviewed officials of the following provider associations:

Kentucky Hospital Association
Kentucky Association of Health Care Facilities
Kentucky Medical Association
Kentucky Pharmacists Association

The degree to which these associations have experienced improvement in conditions varies widely. Pharmacists were on-line to begin with, experienced fewer problems than other providers, and had problems corrected satisfactorily. The executive director of their association stated to Program Review staff that he has not been receiving complaints regarding UNISYS for about three months. He anticipated there might be some transitional difficulty as all pharmacies come on-line, as required, in December.

At the other extreme is the KMA, which last month passed a formal resolution titled "The UNISYS Debacle" (Appendix C), in which it stated:

> RESOLVED, that the KMA House of Delegates recommends that the Commonwealth of Kentucky seek enforcement of the monetary damage provisions available under contract with UNISYS; and be it further
>
> RESOLVED, that liquidated damages, where possible, be made available to pay outstanding claims languishing in UNISYS "pending claims" file; and be it further
>
> RESOLVED, that if UNISYS does not come into compliance with the original contract in the near future that the Commonwealth should seriously consider canceling the contract with UNISYS . . .

Other provider associations recorded a mid-range of concerns. Each stated that, overall, the situation with UNISYS had improved. An official of the Hospital Association stated that an overwhelming majority of suspended claims are from hospitals and that, while things have improved, currently $23 million in hospital claims are suspended more than 30 days. Program Review staff were told that UNISYS is still not paying all claims in 30 days and some are over 90 days past due. Specific complaints cited to staff were:

- System Errors: most frequent cause for claims denials has been a lack of coordination between UNISYS and the Peer Review Organization.
- Lack of Responsiveness from UNISYS: hospitals don't know why claims are suspended and UNISYS will only check 3-5 claims per individual call.

Representatives of the Association of Health Care Facilities observed to staff that a lot of the initial problems have "been ironed out." However, they noted that since 75% of these providers' clients are Medicaid, even small system problems have a significant effect, especially on cash flow. Remaining problems cited were problems with the correct identification of third party liability (erroneous claims denial), Medicare crossover cases, and continuing income allowance cases. These representatives expressed concern that dialogue and cooperation between UNISYS and DMS be vigorous and that both of them involve Medicaid providers in any significant decisions regarding the MMIS system.

APPENDIX A

APPENDIX A

KENTUCKY MMIS FUNCTIONAL AREAS BY SUB-SYSTEMS

FUNCTION	PURPOSE	OBJECTIVE	PERFORMANCE MEASUREMENT	STATUS *
SUB-SYSTEM: RECIPIENT				
Recipient Data Maintenance	Maintain accurate identification and information of those eligible for Ky. medical assistance	Maintain accurate information, update it, transactions, quality control, cross-reference for insurance, on-line eligibility verification	Updated within 24 hours	Operational
Voice Response Eligibility Verification	Automated (by phone) process for confirming recipient eligibility for program services.	Implementation of a state-of-the-art Automated Eligibility Verification System (AEVS).	Sufficient provider access lines for access (not busy) at least 99% of calls made; back-up system to assure downtime doesn't exceed 30 continuous minutes; continuous availability except for agreed upon downtime for updates and preventative maintenance.	Operational
SUB-SYSTEM: PROVIDER				
Provider Data Maintenance	Maintain comprehensive information about providers.	Encourage participation of qualified providers; maintain information to support claims and reports processing.	Staff phones 8-6 M-F; specific requirements for response to calls, letters, and electronic transmittals and requests.	Operational

* Although most functions are operational, penalties continue to be assessed for non-compliance with specific performance standards. According to DMS any penalty indicates that component is unacceptable for that time period, but it doesn't mean that component is not functioning. See Tables 1 and 2 for penalties assessed.

FUNCTION	PURPOSE	OBJECTIVE	PERFORMANCE MEASUREMENT	STATUS
SUB-SYSTEM: TPL				
Third Party Liability (TPL) Processing	To utilize other (e.g. insurance) resources so that Medicaid (and Ky.) is the payor of last resort.	Identify and track third party resources; claims cost avoidance as appropriate; payment recovery as appropriate; meet federal and state reporting requirements; on-line access to information to operate the program.	Copies of claims as specified; update files within payment cycle; generate facsimiles and invoices within Commonwealth time parameters.	Operational
SUB-SYSTEM: CLAIMS				
Alternate Care Processing	Process claims of recipients of services under KY's waiver programs.	Coverage of some services not otherwise available through Medicaid	There is no subsection on this item in the performance expectations in Section 5 of the RFP	Operational
Prior Authorization (PA) Processing	Pre-approval or denial of selected non-emergency services and drugs.	Cost-containment and utilization review; enables approval payment for only that which is medically necessary, appropriate, or cost-effective.	Mail specified notices within 24 hours.	Operational but not functioning properly. Units not being counted correctly.
Claims Control sub-function	Monitor all claims from receipt through disposition for accuracy.	Control over claims transactions (whether hard copy or electronic) during processing; provide accurate registers and audit trails	Assign a unique control number and microform every claim within 24 hours, other specified time requirements for actions.	Operational

FUNCTION	PURPOSE	OBJECTIVE	PERFORMANCE MEASUREMENT	STATUS
Claims Entry sub-function	Enter claims and other transactions into the MMIS for pricing and edit/audit processing.	Ensure the accuracy, reasonableness, and integrity of MMIS entered data for further processing.	Enter hard copy claims within 3 business days; enter magnetic media claims within 24 hours; maintain data entry error rates below approved standards; daily editing;	Operational
Edit/Audit Processing	Ensure that claims are processed in accordance with Ky. policy.	Screen claims for compliance with all program and processing requirements and limitations. Review and correction.	Perform edit/audit processing at least 5 times per month for non-ECM (electronic claims media) claims.	Operational
Claims Pricing	Calculate the payment amount for each service.	Calculate the correct amount according to the applicable rules and limitations.	Execute claims pricing cycle at least 5 times per month for non-ECM (electronic claims media) claims.	Operational
Claims Correction	Support the correction of claims that have suspended during edit and audit processing.	Support as much on-line claims resolution as possible (except for claim correction forms to providers).	Correctly adjudicate all suspended claims except those suspended for medical review within 30 days of receipt and report suspended status to the provider. Correctly adjudicate claims suspended for medical review within 30 days from completion of medical review.	Operational

FUNCTION	PURPOSE	OBJECTIVE	PERFORMANCE MEASUREMENT	STATUS
Claims Operations Management	Provide overall support and reporting for all of the claims processing functions.	Maintain sufficient on-line claims information, provide on-line access to this information, and produce claims processing reports.	Enter recipient and provider history printouts within 1 day of request; produce claims inventory reports after each processing cycle; generate Explanation of Medical Benefits (EMOB) at least every 45 days and within 2 days after the most current payment processing cycle.	Operational
Financial Processing	Process each provider's finalized claims and outstanding accounts (at the end of each cycle).	Ensure that all financial transaction processing (including claim payment, adjustments and accounts receivable) is applied accurately.	Perform payment processing at least 5 times per month; review and adjudicate all provider requests for adjustment within 30 days of receipt.	Operational
Claims Processing Assessment System (CPAS) done by state with UNISYS assistance	System to comply with Federal quality control standards to maintain the maximum level of Federal financial participation.	Meet Federal standards of claims processing timeliness and accuracy by use of analysis of automated samples.	Provide CPAS samples within 5 days ; respond to discrepancy notices with a corrective action plan within 5 days.	Operational
Clinical Laboratory Improvement Amendment (CLIA) Support	To accommodate CLIA requirements. (Medicaid eligible lab services will only be paid if the service is provided by a lab that meets CLIA conditions.)	Successful implementation and monitoring of CLIA requirements.	Apply all provider and reference file updates within federal time constraints; process laboratory claims to comply with CLIA requirements.	Operational

FUNCTION	PURPOSE	OBJECTIVE	PERFORMANCE MEASUREMENT	STATUS
Automated Eligibility Verification System (AEVS) Electronic Claims Capture (ECC)	Partially replace the Voice Response System; add claims submittal by modem service.	Capacity to verify eligibility and accept claims electronically	Submit plans/reports within 15 days of the end of the period; meet objectives within the time specified in the plan; continuous availability except for agreed upon downtime for updates and preventative maintenance; process and respond to ECC claims in 6 seconds or less (timed from reception to beginning of transmittal response.	Operational

FUNCTION	PURPOSE	OBJECTIVE	PERFORMANCE MEASUREMENT	STATUS
Prospective Drug Utilization Review (PRO-DUR) Electronic Claims Management (ECM)	Prepayment review of drug therapy before prescriptions are filled, and direct electronic claims management (prevent the dispensing of inappropriate drugs through direct intervention).	Promote efficiency and cost-effectiveness; eliminate inappropriate use of drugs, develop therapeutic class criteria; establish and maintain drug history profiles, and screen for fraud and abuse.	Submit plans/reports within 15 days of the end of the period; meet objectives within the time specified in the plan; continuous availability except for agreed upon downtime for updates and preventative maintenance; process and respond to POS pharmacy claims in 6 seconds or less, including PRO-DUR review (timed from reception to beginning of transmittal response. Add new providers to the ECM network within 60 days.	Operational

FUNCTION	PURPOSE	OBJECTIVE	PERFORMANCE MEASUREMENT	STATUS
SUB-SYSTEM: REFERENCE				
Reference Data Maintenance	Provides a consolidated source of reference information to be accessed in the performance of other functions.	Provide coding and pricing verification; capability for accommodating changes in the Medicaid programs.	Update reference files within 2 days of notification; provide listings of the Reference files to the Commonwealth within 24 hours of the request.	Operational
SUB-SYSTEM: REPORTING				
Managed Care Processing	On-line processing and reporting for the Kentucky Patient Access and Care System (KenPAC).	Recipient access to medical care through a network of contracted primary care providers, to control Medicaid costs.	Compliance with all applicable state and federal laws; complete specified data within federal time frames.	Partly Operational The parts given definitions by DMS are Operational. Others are not Operational Because no definitions have been given yet by DMS
Drug Rebate Processing	Calculate drug manufacturer rebate amounts (based on federal contracts and the volumes dispensed by the Program).	Meet all Health Care Financing Administration (HCFA) regulations in regard to drug rebate.	Comply with federal time requirements for processing; deliver all rebate checks within 24 hours of receipt; provide at least weekly, and on request, accounts receivable status reports	Operational

FUNCTION	PURPOSE	OBJECTIVE	PERFORMANCE MEASUREMENT	STATUS
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Processing	Identify and track EPSDT services, notify eligible recipients, and evaluate the performance and status of the program.	Provide and encourage continuing health screening and treatment for recipients under 21 to permit early detection and treatment; maximize federal funds for the health care of these recipients.	Apply claims data to the tracking file in the same cycle as the claims are adjudicated to a final status; report according to an agreed upon schedule.	Operational
FUNCTION	**PURPOSE**	**OBJECTIVE**	**PERFORMANCE MEASUREMENT**	**STATUS**
Management and Administrative Reporting (MARS)	Provide programmatic, financial, and statistical reports.	Reports that assist with fiscal planning, control, monitoring, program and policy development, and evaluation of the Ky. medical assistance programs.	For reports specified during the design phase, within 1 day of the production date; response to requests about the reports within 3 days; where there are report deficiencies, correct and rerun within 5 days.	**NOT** Operational
Retrospective Drug Utilization Review (RDUR)	Monitor providers, pharmacists, and recipients for possible drug interaction conflicts, patterns of utilization and inappropriate drug therapies.	Promote efficiency and cost-effectiveness; eliminate inappropriate use of drugs, develop therapeutic class criteria; establish and maintain drug history profiles, and screen for fraud and abuse.	Make all files, reports, profiles, intervention letters and other outputs available per the agreed production schedule.	Operational

FUNCTION	PURPOSE	OBJECTIVE	PERFORMANCE MEASUREMENT	STATUS
SUB-SYSTEM: SURS				
Surveillance and Utilization Review (SURS)	Analyzes data for potential misuse of programs by providers and recipients.	Establish profiles, provide information for investigations, produce reports, and provide data for monitoring.	For reports specified during the design phase, within 1 day of the production date; deliver claim detail reports within 5 days, meet federal requirements for certain file updates and reviews. response to requests about the reports within 3 days; where there are report deficiencies, correct and rerun within 5 days.	Operational

FUNCTION	PURPOSE	OBJECTIVE	PERFORMANCE MEASUREMENT	STATUS
SUB-SYSTEM: STAND ALONE FUNCTIONS				
Ad-Hoc Reporting and Decision Support	Greatly improved access to information to study program characteristics and participant behavior, formulate policy, predict the effects of prospective policy changes and analyze the actual effects of policy changes after implementation.	Permits DMS initiated ad hoc reporting, and data analysis for decision support; tools (software and hardware), training, and support.	Routine reports within 24 hours. Emergency reports within 2 hours unless a different time is mutually agreed upon in writing; data extracts within 3 days; acknowledge receipt of extract specifications within 24 hours; information on extract codes within 3 days after receiving approved specifications for the extract.	Operational
Integrated Test Facility (ITF)	Process test claims and other transactions (without affecting normal operations)	Monitor the accuracy of the MMIS and test proposed changes.	Provide all test outputs within the time periods determined by the Commonwealth.	**NOT** Operational

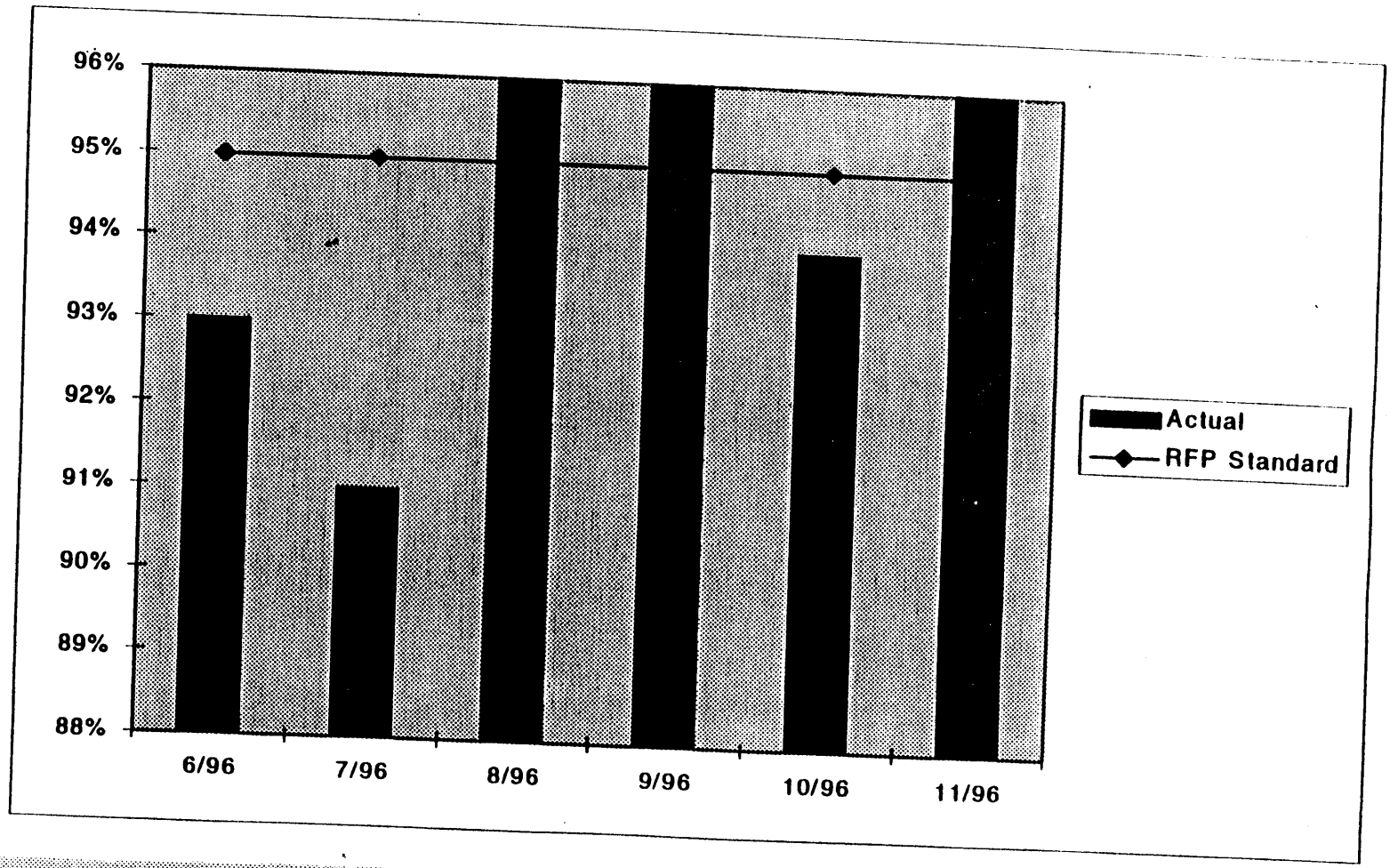
Source: Section 4 and 5 of CHR Management Information RFP, August 8, 1994

APPENDIX B

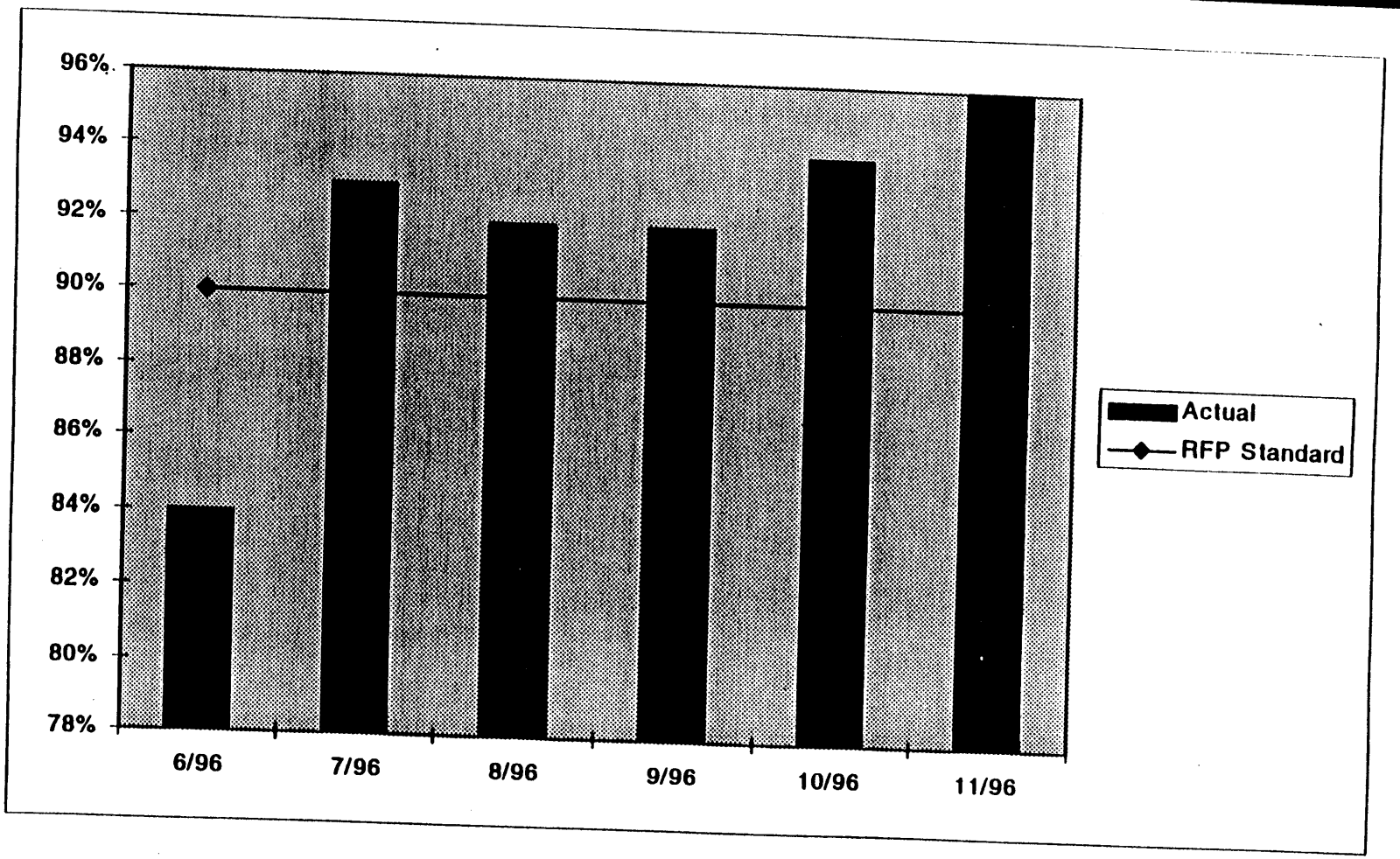
Current Operational Status

November 6, 1996

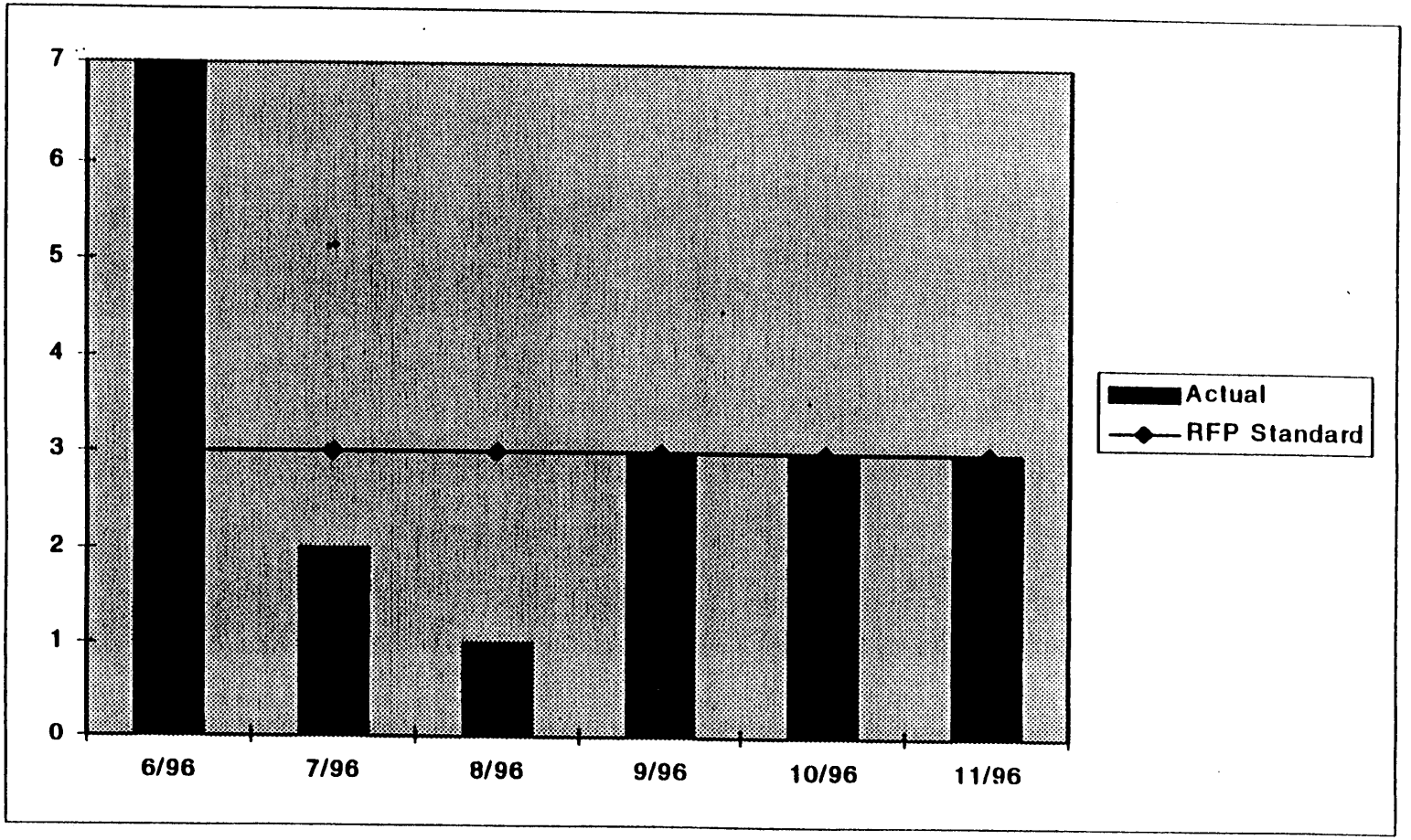
Prior Authorization Service Level



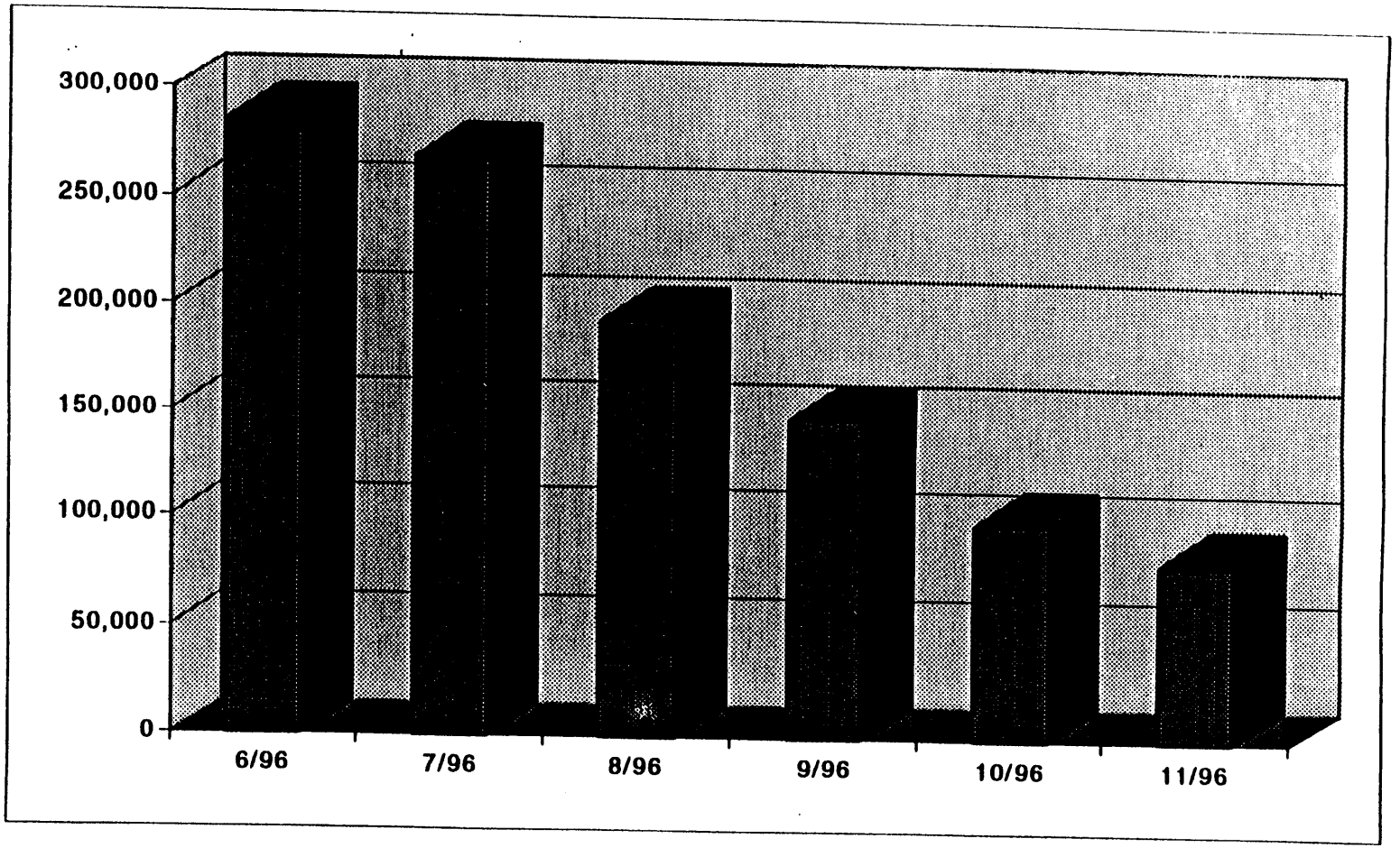
Provider Inquiry Service Level



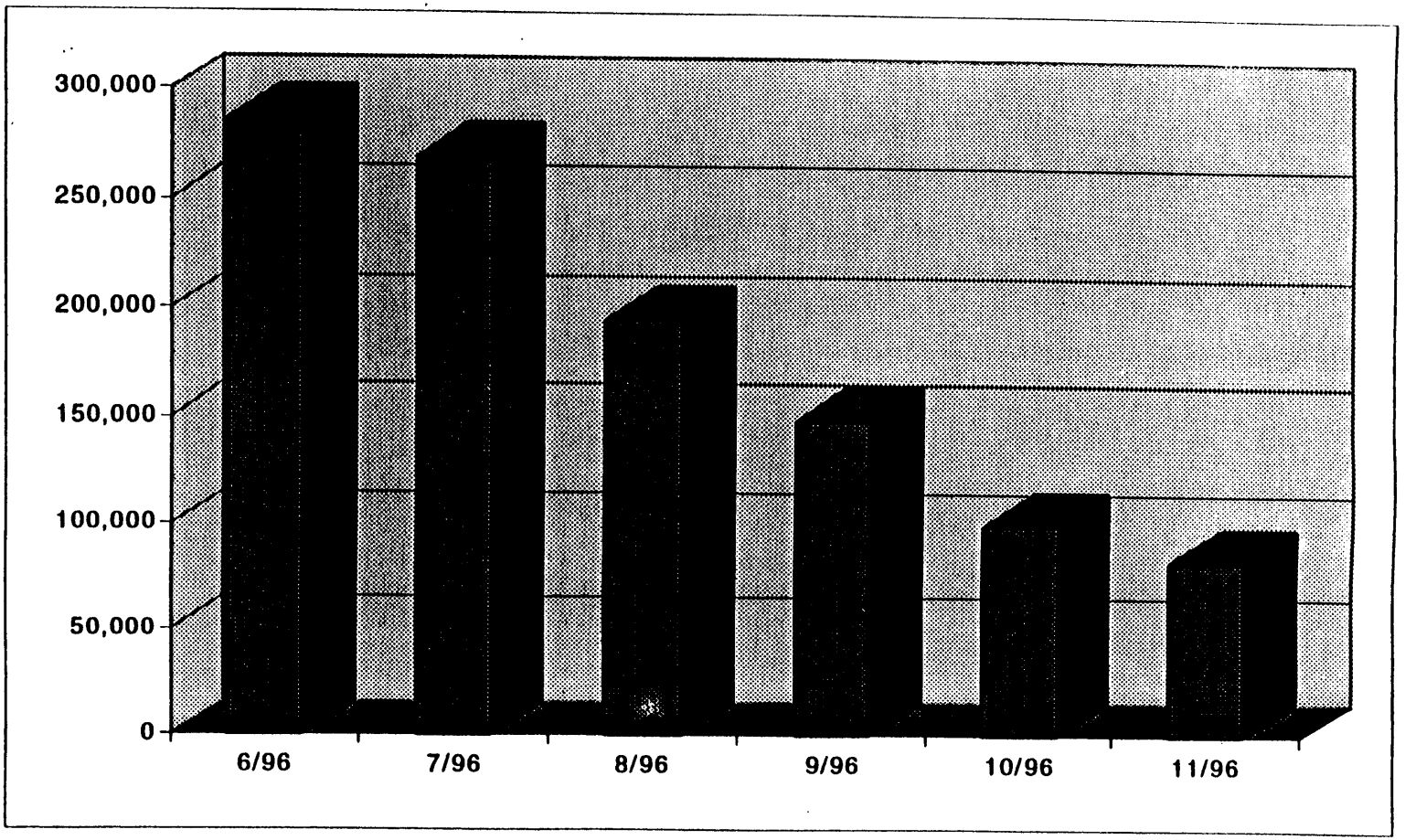
Data Entry
Days Work On Hand



Suspended Claims Inventory



Suspended Claims Inventory



APPENDIX C

Adopted

96-106

RESOLUTION

Subject: The UNISYS Debacle

Submitted by: Board of Trustees

Referred to: Reference Committee D

WHEREAS, UNISYS, the state's fiscal agent charged with processing and paying Medicaid claims, assumed the responsibility in December 1995; and

WHEREAS, despite being operational for over nine (9) months, payments for physicians' claims continue to be delayed, some as long as 120 days; and

WHEREAS, despite repeated assurances from UNISYS officials, claims are still not being processed in an efficient and timely manner; and

WHEREAS, many participating physicians' offices in the Medicaid program are experiencing serious cash flow problems; and

WHEREAS, the Lt Governor of Kentucky, the Secretary for Health Services, and General Assembly Health and Welfare Committees have made Herculean efforts to resolve this problem; now, therefore, be it

RESOLVED, that the KMA House of Delegates recommends that the Commonwealth of Kentucky seek enforcement of the monetary damage provisions available under contract with UNISYS; and be it further

RESOLVED, that liquidated damages, where possible, be made available to pay outstanding claims languishing in UNISYS "pending claims" file; and be it further

RESOLVED, that if UNISYS does not come into compliance with the original contract in the near future that the Commonwealth should seriously consider canceling the contract with UNISYS; and be it further

RESOLVED, that this House of Delegates applauds the efforts made by Lt Governor Stephen L. Henry, MD, Secretary for Health Services John H. Morse, and members of the General Assembly Health and Welfare Committees for working with KMA leadership to reconcile a problem initiated by the previous administration.

KMA House of Delegates
September 1996

APPENDIX D

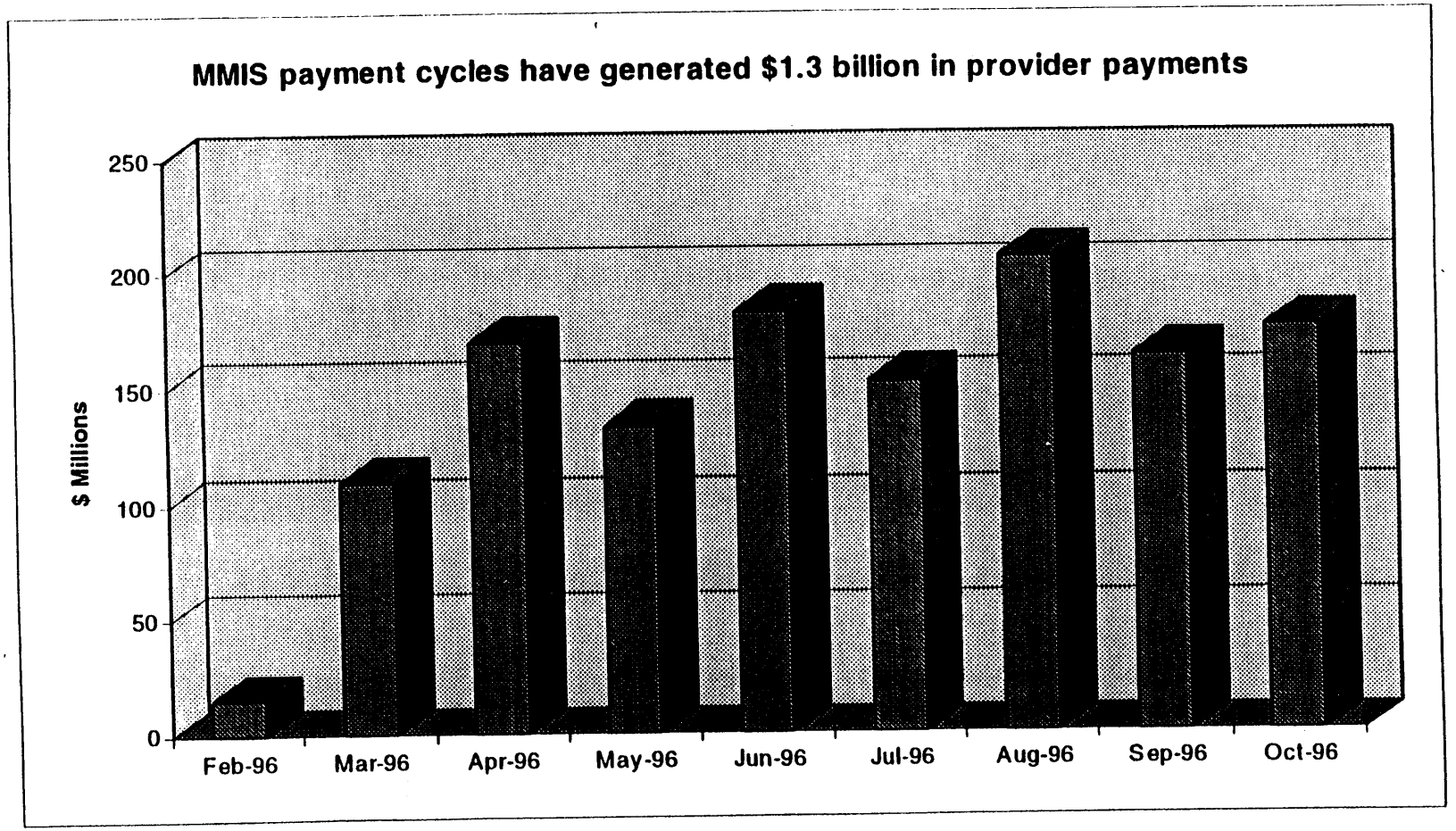
Kentucky MMIS Operational Overview

November 14, 1996

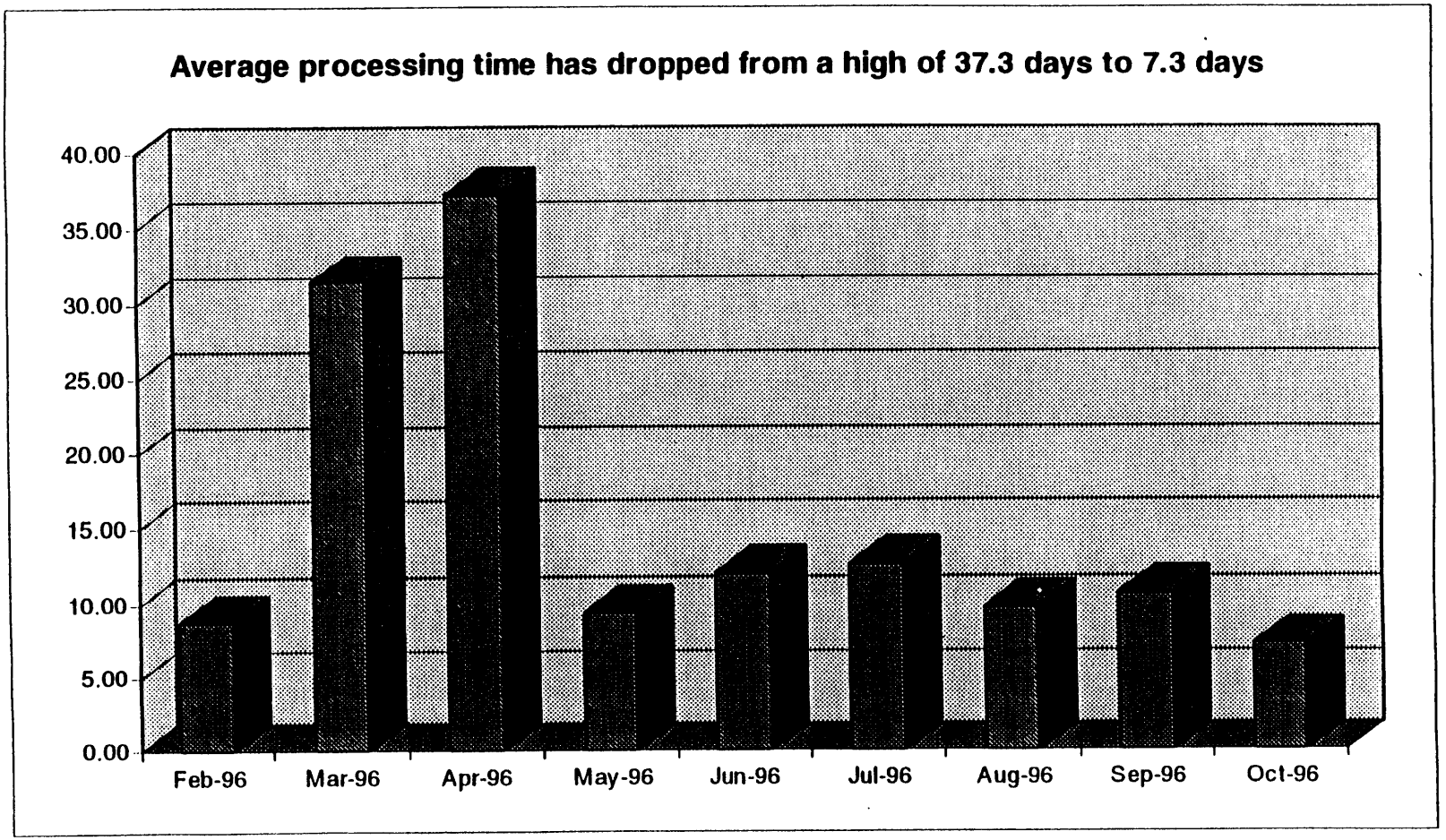
Background

- Unisys began operations effective 12/1/95
- Interim payments were made to providers while the new MMIS was being completed
- Claims processing was initiated in four phases, by provider type
- All provider types were operational by 5/3/96

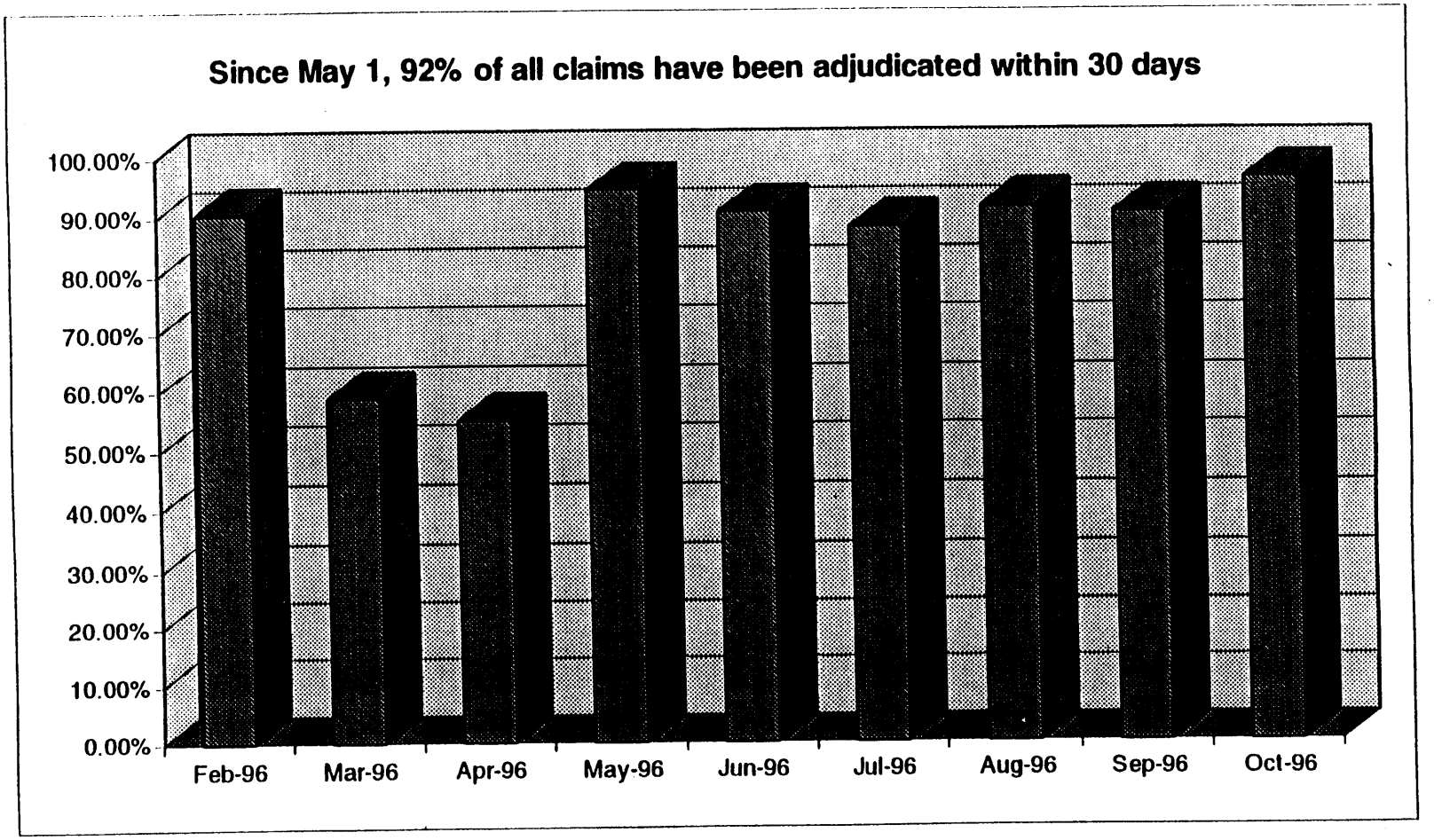
Provider Claim Payments



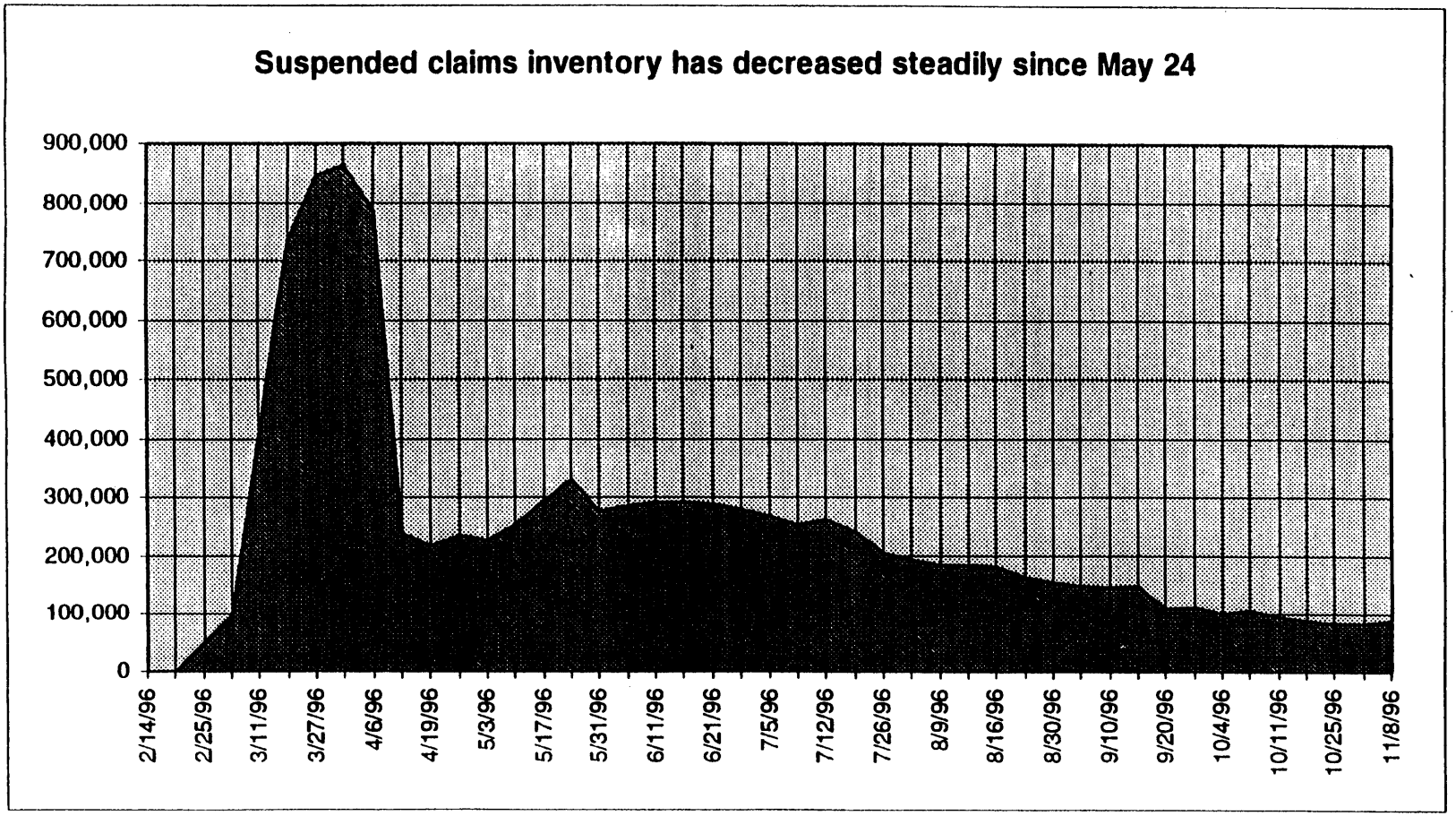
Average Claims Processing Time



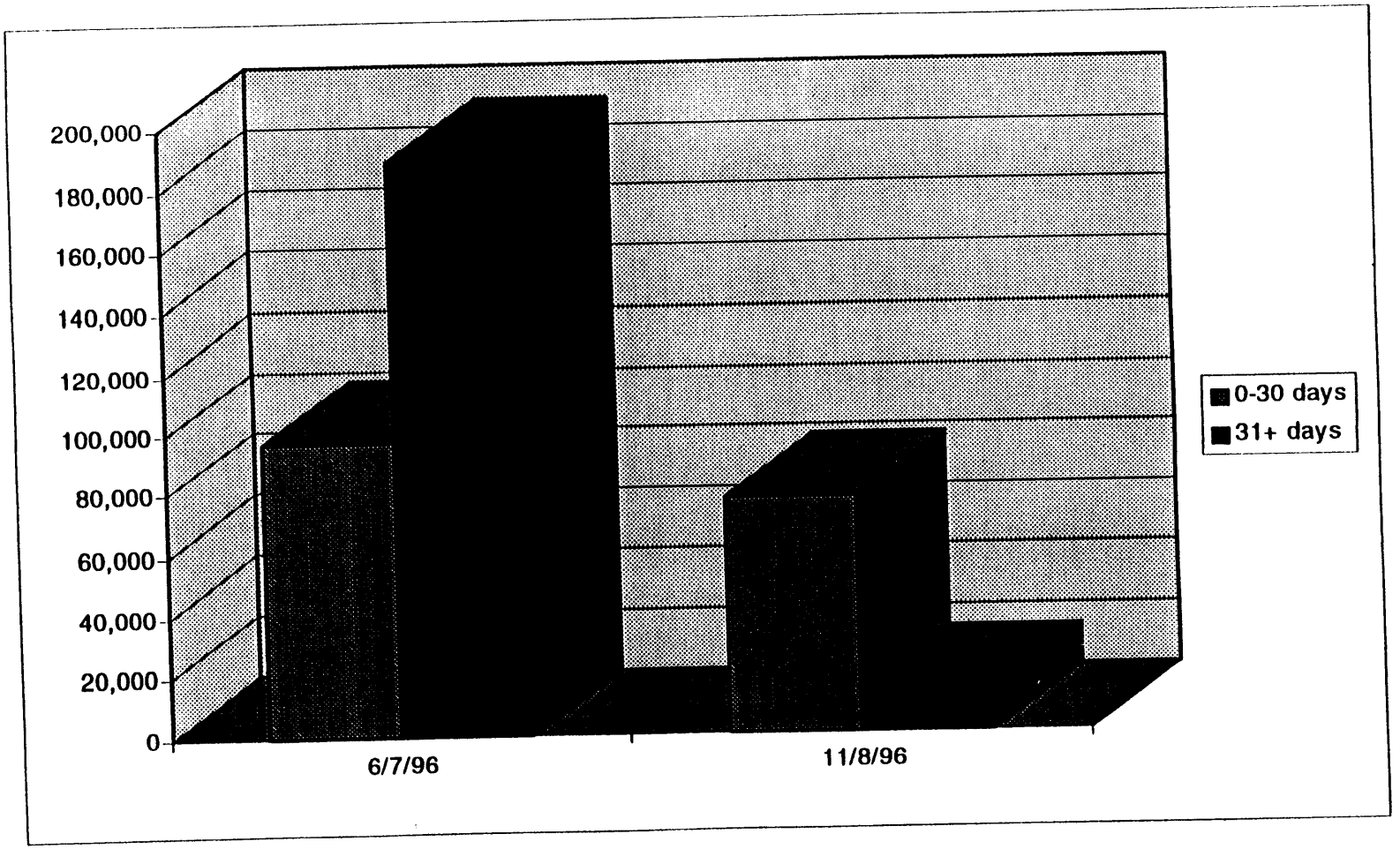
Claims Adjudicated Within 30 Days



Suspended Claims Inventory



Eliminating Aged Claims Inventory



Outstanding Issues

- Completion of Management and Administrative Subsystem (MARS) reporting
  - ↗ *DMS has approved 62% of reports*
- Completion of systems documentation
  - ↗ *DMS has approved format and content of initial deliverable*
- Certification of MMIS by HCFA
  - ↗ *Awaiting completion of MARS and documentation*