

Item No.	Report Code and Report Name	Frequency	Purpose
1	AF-01 Capitation Payment Discrepancy Request	Monthly	To monitor and report capitation discrepancies where the MCO received the incorrect capitation on the monthly 820 file.
2	AF-02 Capitation Payment to Subcontractors	Monthly	To monitor and report on Capitation Payments made to Subcontractors that oversee member benefits of services. This report also serves as a roster of all subcontractors provisioning services for members of the MCO.
3	AF-03 Total Cost of Care (TCOC)	Quarterly	To monitor and report a summary of cost drivers and activities the MCO will conduct to address the drivers and mitigate future cost growth, where possible.
4	AF-04 Expenditures Related to MCO's Operations	Annual	To monitor and report Executive Management's salary, bonus, other compensation, travel and other expenses based upon the reporting period.
5	AF-05 Subcontractor Operations Oversight Report	Quarterly	To monitor and report each entity/Subcontractor of the Contractor, providing evidence of Contractor oversight activities and performance (e.g., performance metrics, corrective actions, sanctions). Include detailed descriptions of entity/subcontractor role, reporting requirements, and performance metrics.
6	AF-06 Annual Managed Care Program Report	Annual	To monitor and report on the overall assessment of operations and impact to quality of care and healthcare outcomes for Enrollees.
7	AF-07 Medical Loss Ratio (MLR) Report	Annual	To monitor and report medical loss ratio for MCO. - EDM template reviewed by Milliman replaces this report
8	AF-08 NAIC Financial Statements	Quarterly	To monitor and report NAIC Quarterly and Annual Financial Statements and Supplements required by the Kentucky Department of Insurance (DOI).
9	AF-09 Statement on Standards for Attestation Engagements (SSAE) No. 18	Annual	To monitor and report on operational audits conducted of the MCO to ensure that sound business practices are in place.
10	AF-11A Audit and Internal Control - Audited Financial Report	Annual	To monitor and report on compliance with the Kentucky Department of Insurance (DOI) requirements for Audit/Internal Control reporting as referenced in the DOI NAIC Checklist for Health.
11	AF-11B Audit and Internal Control - Accountants Letter of Qualifications		
12	AF-11C Audit and Internal Control - Communication of Internal Control Related Matters Noted in Audit		
13	AF-12 Disaster Recovery After Action Report	Annual	To monitor and report the MCO capabilities to manage and recover from a disaster in order to continue to provide enrollee services.
14	BH-01 Behavioral Health Adults and Children Population	Quarterly	To report and monitor behavioral health populations to whom services have been provided during the reporting period.
15	BH-02 Evidence-based Practices Report	Annual	To report and monitor evidence-based practices (EBPs) for behavioral health care employed by the MCO and network providers.
16	BH-04 Behavioral Health Services Hotline	Monthly	To monitor and report behavioral health hotline metrics to ensure crisis intervention support.
17	BH-05 Behavioral Health Population Management	Quarterly	To report and monitor Behavioral Health Program Management statistics by month, by eligibility category and total enrollees.
18	BH-06 Mental Health Statistics Improvement Project Adult Survey Findings Report	Annual	To monitor and report on the experience of care for adult services to ensure member satisfaction and health care outcomes.
19	BH-07 Youth Services Satisfaction Caregiver Survey	Annual	To monitor and report on the experience of care for youth services to ensure member satisfaction and health care outcomes.
20	BH-08 MST Services Report	Semi-Annual	To report on referrals and service utilization for Multisystemic therapy (MST) services in support of the MST Services Pilot evaluation.
21	BH-09 Behavioral Health Prior Authorization Report	Monthly	The purpose of this report is to summarize Behavioral Health (BH) Prior Authorization (PA) volumes and identify key trends across the covered services administered by the Managed Care Organizations (MCOs).
22	CP-01 Original Claims Processed	Monthly	To report and monitor the number and timeliness of original clean claims processed during a reporting period reported by Billing Provider Type (mapped by NPI) and claim status.
23	CP-02 Third Party Liability	Monthly	To report and monitor cost avoidance and recoveries of payments due to Third Party Liability during the reporting period because coverage was determined to be the responsibility of another payer.
24	CP-03 Quarterly Benefits Payment	Quarterly	To monitor and report the financial activity for the Medicaid and KCHIP programs by region, month and state category of service.
25	CP-04 Out-of- Network Provider Report	Quarterly	To monitor and report trending and analysis of non-par providers within the reporting period to address potential gaps and/or future contracting opportunities.
26	CP-05 Prompt Payment	Quarterly	To monitor and report present quarterly claims payment data from the MCO accounting for all clean claims.
27	CP-06 Provider Outstanding Accounts Receivables	Monthly	To monitor and report claims with outstanding accounts receivables 180 days or older. It includes the original accounts receivable amount requested and the current accounts receivable balance for overpaid claims.
28	CP-07 Potential Subrogation	Monthly	To monitor and report cases where an Enrollee has had an accident and there is potential for a liable third party or subrogation claim.
29	CP-08 Provider-Preventable Conditions	Quarterly	To monitor and report information regarding provider preventable conditions (PPC) encountered within the quarter as reported via claims data.
30	CP-09 Payment of Abortion Procedures	Quarterly	To monitor and report that payments made by MCO for abortion procedures are documented and required forms are submitted within this reporting package. This report period is First day of quarter through the last day of quarter and due 15 calendar days following the report period.
31	CP-11 Claim Denials Report	Monthly	To report and monitor denied claims activity and provide an overview of denied claim reasons rankings.
32	ES-01 Enrollment Report	Quarterly	To report and monitor key enrollment data and activities.
33	ES-02 Enrollee Outreach Report	Quarterly	To monitor and report enrollee outreach activities, including summary of activities, enrollee targets and participation, and outreach materials distributed to target populations.
34	ES-03 Enrollee Call Center Report	Monthly	To monitor and report MCO call center performance in the areas of abandonment, blockage rate and average speed of answer. A total for all call center phone lines (main trunk and splits) are to be reported.
35	ES-04 EPSDT CMS – 416 Report	Annual	To monitor and report utilization captured on the EPSDT CMS-416: Annual EPSDT Participation Report.
36	SKY BH-01 SKY Behavioral Health Population	Quarterly	To report and monitor SKY behavioral health populations to whom services have been provided during the reporting period.
37	SKY-02 Clinical and Dental Services	Monthly	To report and monitor the Kentucky SKY enrollee clinical, vision and dental required annual services upon enrollment.
38	SKY-03 Enrollee Appeals and Grievance Activity	Quarterly	To monitor and report any Enrollee Grievance or Appeals activity received or resolved within the reporting period for members of the SKY population; including resolved activity from prior periods. This report will be used to monitor timeliness within the reporting period as well as monitor aggregate data.
39	SKY-04 Provider Appeals and Grievance Activity	Quarterly	To monitor and report any Provider Grievance or Appeals activity received or resolved within the reporting period for members of the SKY population; including resolved activity from prior periods. This report will be used to monitor timeliness of activity within the reporting period as well as monitor aggregate data.
40	PHM-01 Population Health Management Program Report	Quarterly	To report and monitor Population Health Management Program statistics by month, by eligibility category and total enrollees.
41	PHM-02 Complex Care Management Outcomes Report	Quarterly	To report and monitor on outcomes for individuals identified and enrolled in complex care management.
42	PHM-03 D-SNP Population Health Management Report	Quarterly	Track data related to the Dual Special Needs Plan (D-SNP) Medicare-Medicaid members who complete a Health Risk Assessment with their Medicare Advantage Organization (MAO). The MAO will report and monitor Medicare Population Health Management Program statistics by month, by eligibility category and total enrollees in the Dual Special Needs Program.
43	PHM-04 KY D-SNP SNF REPORT	Weekly	MCOs are required to provide timely notification for High-Risk Members not enrolled in a Fully Integrated Dual Eligible Special Needs Plan (FIDE) or Highly Integrated Dual Eligible Special Needs Plan (HIDE) of all admissions to a hospital and skilled nursing facility (SNF) to Department for Medicaid Services "or its designee appointed contact".
44	PHM-05 D-SNP Congruency Report	Annual	Managed Care Organizations (MCOs) offering a Dual Special Needs Plan (D-SNP) are required to provide an annual report to Department for Medicaid Services (DMS) demonstrating a service area network for D-SNP services offered with a congruency of at least 80% with the MCOs Affiliated Medicaid Network by January 31st, of the agreement year.
45	PHM-06 D-SNP D-SNP Auto-Enrollment Activity Report	Quarterly	The Dual Special Needs Plan (D-SNP) Auto-Enrollment Activity Report details the number of individuals in Kentucky who qualify for a D-SNP based on age or disability. The Medicare Advantage Organization (MAO) may auto-enroll the member in a specialized Medicare plan designed for those eligible for both Medicare and Medicaid benefits.
46	PHM-07 Health Risk Assessment Data Report	Quarterly	To report and monitor Population Health Management Program statistics by month, by eligibility category and total enrollees.
47	PHM-08 Notice of Pregnancy Report	Quarterly	Managed Care Organizations (MCOs) receive Notice of Pregnancy (NOP) forms from providers. NOPs allow MCOs to better support members' maternal health. MCOs are to provide a quarterly report to the Department for Medicaid Services (DMS) reporting information related to the NOP for the members for each quarter.
48	PHM-09 MCO Community Events Report	Monthly	Managed Care Organizations (MCOs) are to provide a monthly report to the Department for Medicaid Services (DMS) reporting information related to Community Events (CE). The MCOs will provide information for upcoming scheduled events and participation information from prior events.

49	PSN-01 Denial of MCO Participation	Monthly	To report and monitor any provider or subcontractor who is denied participation with the MCO. Only those providers or subcontractors who are not currently participating with the MCO are to be reported.
50	PSN-02 Provider Credentialing and Contracting Status Report	Quarterly	To report and monitor the credentialing status of providers requesting enrollment by Medicaid provider type and credentialing activity.
51	PSN-03 Provider Network Status Report	Monthly	To report and monitor additions and terminations to the MCO provider network by provider type for network adequacy monitoring purposes. Terminations are required to have a termination reason. The report also includes total provider type network totals.
52	PSN-04 Provider Network Adequacy Exceptions Report	Quarterly	To report and monitor MCO requests and Department decisions that allow for exceptions to the network adequacy standards for reasons such as provider shortages in a particular specialty or geographic location.
53	PSN-05 Geo-mapping and Access Report	Quarterly	To report and monitor MCO's provider network adequacy to ensure that enrollees have access to needed service types by time and distance, and confirm adequacy standards are met. MCOs are to provide separate Geographical Access reports for each county addressing all Provider types specified by the Department.
54	PSN-06 Primary Care Provider Assignment Report	Quarterly	To report and monitor the number of members assigned to a primary care provider (PCP), broken down by a number of stratifications, including summary statistics by region.
55	PSN-07 Primary Care Provider Assignment Changes	Quarterly	To monitor and report Primary Care Provider (PCP) assignment changes during the reporting period.
56	PSN-08 Provider Call Center Report	Quarterly	To report and monitor provider call center statistics on required metrics measured by monthly averages and information about timeliness of resolution of requests.
57	PSN-09 Timely Access Reports	Quarterly	To report and monitor by provider type, if members are able to schedule appointments within contractually required wait times and explain remediation strategies and corrective actions for any deficiencies.
58	PSN-10 Federally Qualified Health Centers and Rural Health Centers	Quarterly	To report and monitor the total amount paid to each Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) per month. All Providers with a specialty of FQHC or RHC are to be reported.
59	PSN-11 Telehealth Services	Quarterly	To monitor and report on utilization of telehealth services by the Medicaid Managed Care population in the Commonwealth of Kentucky. This report will be used to report overall costs, trend volumes, perform comparative analyses, and document the impact of telehealth consultations on the access and quality of care.
60	PSN-12 Network Adequacy of Providers Report	Quarterly	The purpose of this report is to evaluate network adequacy of the Managed Care Organization's (MCO's) network of providers that are not actively servicing Medicaid members within a one-year timeframe.
61	PSN-13 External Independent Third Party Review	Quarterly	The purpose of this report is to monitor the number of EITPR requests each MCO receives, the number of EITPR requests each MCO submits to the Department, and the number of EITPR decisions made by IPRO.
62	PI-02 Overpayment Recoveries	Monthly	To monitor and report on a monthly basis on any identified overpayments which have been recovered during the reporting period.
63	PI-04 Member Lock-In Report	Monthly	To monitor and report the membership participating in the Lock-In program as well as the reduction in utilization achieved from that membership's participation.
64	PI-05 Explanation of Member Benefits (EOMB)	Monthly	To monitor and report on the MCO's activities in verifying member benefits were rendered as billed and reported by providers.
65	PI-06 Division of Program Integrity Monthly Dashboard	Monthly	To monitor and report on the MCO's core activities in demonstrating on monthly basis their ability to combat Fraud, Waste and Abuse as prescribed in Contractual Section 34.0 Program Integrity and Appendix I Program Integrity Requirements.
66	QM-01 Enrollee Grievances and Appeal Activity	Quarterly	To monitor and report any Enrollee Grievance or Appeal activity received or resolved within the reporting period; including resolved activity from prior periods. This report will be used to monitor the timeliness of activity as well as monitor aggregate data.
67	QM-02 Provider Grievances and Appeal Activity	Quarterly	To monitor and report any Provider Grievance or Appeal activity received or resolved within the reporting period; including resolved activity from prior periods. This report will be used to monitor the timeliness of activity within the reporting period as well as monitor aggregate data.
68	QM-03 QAPI Status Reports	Quarterly	To improve health care outcomes and performance measure results by monitoring, evaluating, and reporting progress towards goals and metrics outlined by each Managed Care Organization's (MCOs) Quality Assurance and Performance Improvement programs.
69	QM-04 QAPI Annual Report	Annual	To monitor and report on insights and transparency into the progress and metrics towards goals outlined by MCO's Quality Assurance and Performance Improvement programs.
70	QM-05 PIP Status Report	Quarterly	To monitor and report on insights and transparency into the progress towards goals and metrics for MCO's Performance Improvement Projects.
71	QM-06 Member Satisfaction Survey Report	Annual	To report and monitor survey results of Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction as completed by a third party, NCQA certified vendor.
72	QM-07 Provider Satisfaction Survey Report	Annual	To report and monitor results of provider survey results as obtained by a pre-approved MCO tool prior to survey engagement. This report will provide insight of interventions and progress year-over-year from surveys completed.
73	QM-08 Audited HEDIS Reports	Annual	To report and monitor HEDIS results that indicate the clinical quality performance of MCO membership to support population health management and improvement.
74	QM-09 Quality Improvement: Monitoring Indicators, Benchmarks and Outcomes	Annual	To monitor and report activities that transform the Medicaid program to empower individuals to improve and engage in their healthcare and to drastically improve quality of care and healthcare outcomes and to reduce or eliminate health disparities. To support these goals, the MCO will implement innovative and strategic solutions to Quality Management and improvement and collaborate with the Department and other contracted MCOs, to develop a data-driven, outcomes-based continuous quality improvement process.
75	QM-10 Enrollee Disenrollment for Cause Requests	Monthly	To monitor and report on Enrollee Disenrollment for Cause requests received and/or resolved within the reporting period; including resolved activity from prior periods. This report will be used to monitor volumes, timeliness, and outcomes of these requests to include state appeals and fair hearings.
76	QM-11 MCO Dashboard Report	Quarterly	This report aims to consolidate key data metrics from various reports into a single, comprehensive dashboard submission. This dashboard will enable the Department for Medicaid Services (DMS) to compare data across all Managed Care Organizations (MCOs), ensuring consistency and quality of the data from each MCO partner.
77	QM-12 Interop Rule Status Report	Monthly	The CMS Interoperability and Prior Authorization final rule (CMS-0057-F) builds on CMS' previous rule (CMS-9115-F) by outlining requirements for additional information via the Patient Access API and new requirements to implement three additional APIs: Provider Access API, Payer-to-Payer API, and Prior Authorization API. The APIs finalized in both final rules must meet certain technical standards to drive interoperability and increase provider and patient access to health information. Compliance with this rule is required by January 1, 2027. The Department will monitor the MCO's progression to compliance with CMS standards.
78	UM-01 Prior Authorizations Report	Monthly	To monitor and report on the prior authorization (PA) activity during the reporting period, including the number of requests for service authorizations and the number approved or denied in accordance with KRS 205.534.
79	UM-02 Utilization Report	Quarterly	To monitor and report on a summary of MCO findings of over- and under-utilized services for the reporting period and trended over timeframes as determined by Department.
80	UM-03 Utilization of Subpopulations and Individuals with Special Healthcare Needs	Quarterly	To monitor and report on utilization of Subpopulations and Individuals with Special Healthcare Needs as defined in the contract.
81	UM-04 Behavioral Health Services In/Out State Facility Utilization	Monthly	To monitor and report on Behavioral Health (BH) services placement information for members. The report should include all members under age 21 that are in a facility for 10 days or more in and out of the state of KY for a BH service no matter what service they are receiving. If the member is in a facility and receiving an EPSDT Special Service, it should be reported.
82	UM-05 Utilization Management Program Evaluation	Annual	To monitor and report on findings from the MCO's annual Utilization Management Program evaluation, including: an assessment of effectiveness in improving clinical and service outcomes, and a discussion of identified changes, if any, the MCO plans to make to the program to address challenges or increase effectiveness. The evaluation shall also include assessment of UM activities conducted by Subcontractors.
83	UM-06 Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death	Quarterly	To monitor and report on services and health activities related to EPSDT, pregnant women, as well as maternal and infant death.
84	UM-07 Adult Guardianship Clients	Monthly	To monitor and report on adult guardianship enrollees by region.

85	UM-08 Value Added Benefit (VAB) Utilization Report	Quarterly	Managed Care Organizations (MCOs) offer Value Added Benefits (VABs) to better support members' medical and non-medical needs. VABs are additional services that are outside of the Medicaid benefit package but that seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care. MCOs are to provide a quarterly report to the Department for Medicaid Services (DMS) demonstrating the member utilization of VABs per Category Type and per Resource Type for each quarter.
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