SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

648

FROM: Human Resources Department

SUBMITTAL DATE:
April 11, 2012

SUBJECT: Software System Support upgrade of the Monument Systems Claims Payment and Eligibility System, Version 3.10 including Electronic Claims Submission Module and Microsoft "Biz Talk".

RECOMMENDED MOTION: That the Board of Supervisors 1) ratify and approve the attached addendum with Monument Systems, LLC, (formerly Health Trio Inc.) to support this sole source procurement system upgrade Version 3.10 including Electronic Claims Submission Module and Microsoft "Biz Talk"; and 2) authorize the Chairperson to sign three (3) copies of the attached addendum, retain one copy of the signed addendum, and return two (2) copies to Human Resources for distribution. Exclusive Care is a health insurance plan option funded by member premiums and administered by the Human Resources Department for the County of Riverside members and their families.

Barbara A. Olivier
Asst. County Executive Officer/Human Resources Dir.

Departmental Concurrence

FINANCIAL DATA				
	Current F.Y. Total Cost:	$ 166,000	**In Current Year Budget:**	Yes
	Current F.Y. Net County Cost:	$ 0	**Budget Adjustment:**	No
	Annual Net County Cost:	$ 0	**For Fiscal Year:**	2011/12

SOURCE OF FUNDS: Exclusive Care premiums paid by enrolled membership.

Positions To Be Deleted Per A-30 ☐

Requires 4/5 Vote ☐

C.E.O. RECOMMENDATION:

APPROVE

County Executive Office Signature

BY: Elizabeth J. Olson

☒ Policy ☐ Consent

☒ Policy ☐ Consent

Dep't Recomm.:

Per Exec. Ofc.:

Prev. Agn. Ref.: 11\26\2002 - # 3.55, 10/19/2004 - #3.25, 11/4/2008 - #3.36, 4/6/2010 - #3.47, 8/16/2011-#3.58

District: ALL

Agenda Number: 3.20

G:\EXEC\Form 11\EPO Provider Contracts\2012 Contracts\Monument Systems Version 3.10 Upgrade.doc

ATTACHMENTS FILED
WITH THE CLERK OF THE BOARD

BACKGROUND:

On November 26, 2002, the Board of Supervisors first approved an agreement with Monument Systems, LLC (formerly Health Trio) to purchase and install the current claims payment, eligibility and health information system for Exclusive Care. The software used in this system was designed by Monument and is unique and proprietary in nature. The current Service Agreement with Monument Systems, LLC is effective for the period July 1, 2009 through June 30, 2012 and covers the annual maintenance fee and software support for the current system configuration.

For FY 2011-12 Exclusive Care is budgeted to adjudicate and pay over $36 million in medical and hospital claims using the health information system purchased from Monument Systems, LLC. The system must insure timely and accurate claims payments and remain in compliance with current regulations, including processing mandates required by the Health Insurance Portability and Accountability Act (HIPAA) and The Centers for Medicare & Medicaid Services (CMS) data regulations. In particular, this 3.10 system upgrade will support compliance with HIPAA ASC X12 Version 5010, the Federal standard that will regulate the electronic transmission of specific healthcare transactions, including eligibility, claim status, referrals, claims, and remittances.

Exclusive Care and other covered entities, such as health plans, healthcare clearinghouses, and healthcare providers, are required to conform to the new transaction set standards. In addition, this upgrade will allow Exclusive Care to comply with mandatory ICD-10-CM and ICD-10-PCS code sets, scheduled for implementation on October 1, 2013. These additional administration system updates are not covered by the current maintenance agreement.

In addition to these compliance functions, this upgrade and Electronic Claims Submission module including Microsoft "Biz Talk" is designed to improve claims processing quality, efficiency, data integrity and cost reduction by providing electronic connectivity with all medical providers. It will facilitate the submission of Riverside County Regional Medical Center and all other hospital and medical claims to Exclusive Care electronically.

We have negotiated pricing with Monument Systems for the best preferred customer discounts resulting in a $25,000 discount off the normal license price and we are receiving pricing equal to or better than any other comparable customers.

Exclusive Care receives more than 2,500 paper claims weekly, and uses 3.5 claims processors to manually enter data and adjudicate these claims. Membership increases, and a growing volume of claims requires improvements that cannot be achieved without increased automation. Exclusive Care will increase processing productivity by greater than 10% with the full implementation of this program. These gains in productivity will both offset increasing administrative costs and reduce claims unit processing and staffing costs as efficiency improves. These system and processing changes will reach projected productivity performance gains within 24 months of full implementation. The system upgrade cost will not exceed $166,000 and has been budgeted in the Exclusive Care program for FY 2011-12.

There is no direct cost to the County for the recommended action as these costs are funded by Exclusive Care premiums paid by members.

Date: 3/7/2012

From: Barbara A Olivier Department/Agency: Human Resources
To: Board of Supervisors/Purchasing Agent

Via: Purchasing Agent

Subject: Sole Source Procurement; Request for version 3.10 and EDI upgrades from Monument Systems LLC for the Health Trio claims and medical management processing system used by Exclusive Care.

This information is provided in support of my Department requesting approval for a sole source.

1. **Supply/Service being requested:** Software System Support upgrade of the Monument Systems claims payment and eligibility system (Health Trio version 3.10) including the Electronic Claims Submission (EDI) module and Microsoft "Biz Talk".

2. **Suppliers being requested:** Monument Systems, LLC and Microsoft "Biz Talk" under terms of the County's Public Sector Enterprise Agreement.

3. **Alternative suppliers that can or might be able to provide supply/service:** This is an upgrade and maintenance to the current operating software for the existing system. There are no other sources of support for the Health Trio claims processing system other than the vendor that developed the system. The fees negotiated represent best efforts to manage the ongoing costs of maintaining and enhancing the service capabilities of this operational system.

4. **Extent of market search conducted:** Monument Systems provides claims processing software to public and private entities throughout the US. The Health Trio express system remains a cost effective solution to meet the various operating and administrative functions performed by Exclusive Care. This upgrade further refines its capabilities. There are no software solutions on a standalone basis from other market vendors that integrate into this system.

5. **Unique features of the supply/service being requested from this supplier, which no alternative supplier can provide:** This proprietary 3.10 version upgrade and EDI module is designed to support compliance with regulations, claims processing quality, efficiency, data integrity, cost reduction and enhance electronic connectivity with all medical providers. In particular, this system upgrade will support compliance with the Health Insurance Portability and Accountability Act (HIPAA) ASC X12 version 5010, the Federal standard that will regulate the electronic transmission of specific healthcare transactions, including eligibility, claim status, referrals, claims, and remittances. Exclusive Care and other covered entities, such as health plans, healthcare clearinghouses, and healthcare providers, are required to conform to the new transaction set standards. In addition, this upgrade will allow Exclusive Care to comply with mandatory ICD-10-CM and ICD-10-PCS code sets, scheduled to be implemented on October 1, 2013.

6. **Reasons why my department requires these unique features and what benefit will accrue to the county:** Exclusive Care receives more than 2500 paper claims weekly, and uses 3.5 claims processors to manually enter data and adjudicate these claims. Membership increases, and a growing volume of claims requires

Care will increase processing productivity by greater than 10% with the full implementation of this program. These gains in productivity will both offset increasing administrative costs and reduce claims unit processing and staffing costs as efficiency improves. These system and processing changes will reach projected productivity performance gains within 24 months of full implementation.

7. **Price Reasonableness:** Fees for both the system upgrades and implementation costs have been negotiated with the vendor. These prices represent preferred client discounted pricing.

8. **Does moving forward on this product or service further obligate the county to future similar contractual arrangements or any ongoing costs affiliated with this sole source?** Monument Systems continues to maintain the Health Trio system through ongoing service agreements. Those service costs will continue.

9. **Period of Performance:** Not Applicable

Barbara A. Olivier 3/7/12

Department Head Signature Date

Barbara A. Olivier
Asst. County Executive Officer
Human Resources Director
Exclusive Care Plan Administrator

Purchasing Department Comments: NOT TO EXCEED $160,000

Approve Approve with Condition/s Disapprove

Purchasing Agent 3/12/12 # 12-446

Date

Form # 116-333 rev 3/28/11

MONUMENT SYSTEMS
EXPERIENCE ♦ PERFORMANCE ♦ INNOVATION

Addendum To the *xpress*™ Software System Support, Maintenance Agreement Between County of Riverside on Behalf of the Exclusive Care Division of its Human Resources Department and HealthTrio, Inc.

This Addendum ("Addendum") is effective as of the latest date below (the "Effective Date") between Monument Systems, LLC, a Colorado Limited Liability Company ("Monument Systems"), and County of Riverside on Behalf of the Exclusive Care Division of its Human Resources Department ("Licensee") to amend the License Agreement (the "License Agreement") and the Software System Support and Maintenance Agreement (the "SSSMA") between HealthTrio, Inc., and Licensee, dated December 31, 2002 and all amendments and addendums thereto (collectively, the "Agreements"). In the event of a conflict between the Agreements and this Addendum, the provisions of this Addendum will be deemed controlling.

Whereas Licensee desire to license additional software, specifically the EDI Module, from Monument Systems, and receive maintenance thereto, and whereas Monument Systems desires to provide same to Licensee, the parties acknowledge the need to and agree to modify the Agreements as follows:

1. EDI Module. Monument Systems hereby licenses to Licensee the EDI Module described in Schedule 1 hereto. Exhibit A of the License Agreement shall be replaced, in its entirety, by Schedule 1 hereto. Schedule 1 describes the System as currently licensed by Licensee.

1.1 Term. The term of the license to the EDI Module, and maintenance for the EDI Module, shall be for five (5) years from the latest date of signature below.

1.2 License Fee. The license fee for the EDI Module only shall be $85,000.00, which represents the preferred client discounted price over the list price of $110,000.00. Such fee shall be due and payable upon execution of this Addendum.

1.3 Maintenance Fee. The maintenance fee for the EDI Module shall be $22,000.00 annually, which represents twenty percent (20%) of the list price of the EDI Module. Such fee shall be due and payable upon the System Installation Date of the EDI Module and due thereafter annually along with the maintenance fees due under the SSSMA for the term of this Addendum. If necessary, Monument Systems shall bill a pro-rated amount in 2013 in order to align the EDI Module maintenance fee and the maintenance fee due under the SSSMA.

1.4 Implementation of the EDI Module. Monument Systems shall implement the EDI Module at a flat rate of $35,880.00. Such rate is a one-time fee

that shall be due and payable from Licensee to Monument Systems upon execution of this Addendum. Implementation details shall be agreed upon in a mutually agreed upon Statement of Work ("SOW"). If Licensee fails to pay the amount due upon its execution of this Addendum, such rate shall expire; however, Licensee shall still be bound to pay to Monument Systems the current rate for such implementation.

1.5 Assumptions. The parties agree that, for Licensee to use the EDI Module, Licensee must: (1) license Microsoft BizTalk 2010; (2) migrate to *xpress* 3.10; and (3) devote sufficient resources, including the appointment of an executive project sponsor, to oversee and provide support for the collaborative process necessary for a successful implementation. Any failure to do undertake any of these actions shall not be construed against Monument Systems.

2. This Addendum supplements, amends and is incorporated, to the extent identified above, into the Agreements. This Addendum shall remain in effect until the Agreements, as amended herein, expire or are terminated in accordance with their terms or this Addendum. Except as modified by this Addendum, the Agreements shall remain in full force and effect, and their terms and provisions are hereby ratified and confirmed subject to the terms and conditions of this Addendum.

This Addendum is hereby executed as of the latest date below written.

Monument Systems, LLC	***County of Riverside On Behalf of the Exclusive Care Division of its Human Resources Department***
By: _____	By: _____
Asma Hasan	John F. Tavaglione
Title: Chief Legal Officer	Title: Chairman of the Board of Supervisors
Date: March 12, 2012	Date: _____, 2012

FORM APPROVED COUNTY COUNSEL
BY: _____ DATE
NEAL R. KIPNIS

MONUMENT SYSTEMS

EXPERIENCE ◆ PERFORMANCE ◆ INNOVATION

Schedule 1
System Features and Function

xpress 3.10

Monument Systems *xpress*™ Base

System Security

Within a User's profile, the System Administrator is able to set up Database Level Security, as well as User Security. The System Administrator can re-set passwords, terminate Users, establish User confidentiality levels and assign application time-out settings. Time-out settings allow the application to be masked after a specified period of inactivity and the original signed-on User must re-sign on to each timed out application before access will be re-granted.

Set-up and Maintenance of Security Profiles by System Administrator(s)

- Search Capabilities by:
    - User ID
    - User Name
    - User Department
    - User Profile
    - Profile Name
    - Profile ID
- Search Text by:
    - Equal to
    - Starts with
    - Contains
- Assignment of Users to Profiles
- Security Profiles determine the level of User access and System functionality
- Users can be limited in their access to multiple Databases via Database Profiles
- Users with full access to a module are able to open the module in Display Mode and Update Mode
- Update and terminate Users
- Capability to change passwords
- Tabs can be excluded from display capability.
- Security can be defined for the following Tabs:
    - Diagnosis
    - Procedure Codes
    - Services within Referrals

Schedule 1
System Features and Function

  - Authorizations
  - Medical Claims
  - Hospital Claims

- Medical and Hospital Claims diagnosis combo box has display security settings.
- Minimum Necessary Disclosure limits view of Diagnosis and Procedure data to only authorized users.

Activity Log (Show Log)

Monument Systems *xpress*™ provides a Log of each User's activity which can be used to monitor activity, and is a convenient method of returning to recently processed information. The Activity Log lists activity performed by the current User.

Any Record listed in the Activity Log can be opened, simply by double-clicking on the entry in the log, providing quick and convenient access to the Record.

The following information is available for each entry in the Log:

- The module (function) in which the activity took place
- The type of activity
- The Member, Provider, Group, or other entity named on the Record
- The Record Number
- The date on which the activity was performed
- The time at which the activity was performed

The Activity Log can be sorted by the information in any of the columns. Sorting allows the User to find information quickly, to determine which areas of the system are most frequently visited, and which actions are most often performed.

Global Tables

The functionality and flexibility of Monument Systems *xpress*™ is supported by its Codes and Tables. These Tables contain User and System defined Codes, Rules and parameters, which control the operation of the system.

Organizations

Demographic, contact and financial information about organizations is stored in the Organization Tables. The Organization Tables each contain site-specific information about Carriers, Networks, Payers and site-specific demographics.

Diagnosis Codes

The Licensee must have the appropriate licensure to receive the pre-loaded Diagnosis Codes through the current year with Monument Systems *xpress*™. When a Provider sees a Member, the Provider will indicate the Diagnosis Codes or Codes that apply to the visit. These Codes are used to determine coverage, as well as define the clinical reason for the visit.

Schedule 1
System Features and Function

The Licensee is responsible for maintaining the Code Set.

Operation Codes

The Licensee must have the appropriate licensure to receive the pre-loaded Operation Codes pre-loaded through the current year, with the complete list of ICD-9-CM Procedure Codes (International Classification of Diseases, Ninth Revision) and ICD10-CM Procedure Codes when available, which represent the specific surgical procedures performed by Hospital Providers.

The Licensee is responsible for maintaining the Code Set.

Procedure Codes

The Licensee must have the appropriate licensure to receive the pre-loaded HCPCS (Healthcare Common Procedure Coding System) Codes and CPT (Current Procedural Terminology) Codes through the current year.

CPT (Current Procedural Terminology) Codes reference specific billable medical procedures that may be performed by Providers. In Monument Systems *xpress*™, information related to the handling of payments for procedures to which no modifier applies is stored directly on the CPT (Current Procedural Terminology) Record.

In some situations, a Modifier may apply to a Procedure Code. Information about Modifiers is stored on a separate, but related, CPT (Current Procedural Terminology) Modifier Record.

The Licensee is responsible for maintaining the Code Set

Modifiers

Modifiers may increase or reduce the covered amount of a CPT (Current Procedural Terminology) Code. Modifier calculations can be varied by Network, Carrier, Product and business combinations. Pricing will use the first two Modifiers submitted, but the system can track four Modifiers at each procedure line.

MONUMENT SYSTEMS

EXPERIENCE ◆ PERFORMANCE ◆ INNOVATION

Schedule 1
System Features and Function

Revenue Codes

The Licensee must have the appropriate licensure to receive Revenue Codes pre-loaded through the current year with Monument Systems *xpress*™.

Revenue Codes (UB04 Codes) are used in processing Hospital Claims; these Claims use Revenue Codes to identify Services, Procedures, Supplies or Materials. In Monument Systems *xpress*™ the Revenue Codes Table is used to automatically and accurately price line items for Hospital Claims.

The Licensee is responsible for maintaining the code set.

NDC Codes (National Drug Codes)

The Licensee must have the appropriate licensure to receive NDC Codes pre-loaded through the current year with Monument Systems *xpress*™. NDC Codes can be added at the procedure line level on Medical Claims.

The Licensee is responsible for maintaining the code set.

Claim Edits

Claims Edits are system-defined for Medical and Hospital Claims, and can vary the action to Review, Pend, or Deny based on the edit.

Quick Pay/Slow Pay

Quick Pay/Slow Pay allows Clients to set up Schedules which will calculate and apply a discount or penalty to Claims based on a range of days, dates at a daily rate, or flat percentage rate. These Schedules can be attached to Providers and Hospitals and can be varied by contract.

The calculation is based on the check date to:

- Original Date the claim was received
- The date that the claim became a clean claim

Global Codes

A base set of Global Codes come pre-loaded to assist in the configuration of the system. Typically these Code Sets are then modified by each Client. Global Codes are used to populate dropdown lists from which values can be selected. The ability to select values from lists makes data entry quick and less error prone.

- Definition of Global Tables allows definition of entries specific to individual business needs.

Schedule 1
System Features and Function

Rules Based Logic Forms

Rules Forms allow the client to define Rule Types using and/or logic. All of the Rules must be satisfied for the Rule Type to apply.

Auto PCP Rules

The system can automatically assign a PCP when the submitted PCP is missing. It can be turned On or Off by business segment, Group, division, region and/or subgroup. Providers that are not primary care Physicians or that do not qualify for the Member (due to age, gender, panel size limitations and contract period as defined on the physician record) are filtered out. The option to assign to a PCP who is not accepting new Patients can be set by the User.

- Rules defined at a specific level will take precedence over Rules defined at a more ambiguous level
- The PCP with the highest score will be assigned to the Member.

  (A minimum score that a member/PCP combination must have before a PCP can be assigned can be set.)
- Scores will be calculated from a grouping, rank, priority, necessity (must have) and disallow (prohibit) considerations

  (A tie-breaking mechanism can be determined to choose a PCP, when 2 PCPs have the same score.)
- User-defined Rules can include, but are not limited to: Age, Zip Code, Region, Language, etc.
- A default PCP can be designated when no PCP can be assigned or is required

Carrier Notes

Carrier Notes is a way to setup Exception Notices for Referrals, Authorizations, Medical, Hospital Claims and Services that meet the criteria for the Defined Rules. Rules can be varied by Business Segment (Network, Carrier, Product and Business) and a multitude of Code Types such as: Bed Type, Diagnosis, Location, Age, Gender Provider, Hospital, Cost, Units, Contract, and Specialty.

Division of Financial Responsibility

The Division of Financial Responsibility sets up of risk or delegated arrangements for automatic denial adjudication that meets the criteria for the Defined Rules. Rules can be varied by Business Segment (Network, Carrier, Product and Business) and a multitude of Code Types such as: Bed Type, Diagnosis, Service, Current Procedural Terminology, etc.

Schedule 1
System Features and Function

Medical Management Grouping

Medical Management Grouping allows the Client to build Rules to vary the level of matching when assigning Referrals or Authorizations to Medical or Hospital Claims. Rules can be varied by Business Segment (Network, Carrier, Product and Business) Current Procedural Terminology, Revenue Codes, Services and Bed Type.

Pre-Existing Rules

Clients can define conditions that can be associated into bundles assigned to Employer Groups or individual Members. Pre-existing condition Rules assigned to the Member overrides the Groups pre-existing conditions. Pre-existing dates are based on the credible coverage dates. Rules can be varied by several Code Types: CPT, DX, Location and Revenue codes.

Provider Specialty Rules

Rules may be built that specify the types of services a Provider and/or Provider Specialty may be reimbursed for by the Health Plan and automatically deny those services not covered.

Rules can be varied by business segment and a multitude of Code Types such as: age, gender, Current Procedural Terminology, diagnosis, location etc.

Referral/Authorization Rules

Clients can set up Rules for the types of services or procedures that do not require a Referral or Authorization. Rules can be varied by business segment and a multitude of Code Types such as: hospital or provider ID, Current Procedural Terminology, modifier, diagnosis, location, etc.

Service Rules

Rules can be set up that define a set of criteria that meet a Service Rule that can automatically be assigned to a Claim when the user saves the Claim. Within the Fee Schedule, the Service can be defined to pay at a set computation method which would be applied at the Claim level. The Rules can be varied by the business segment and a multitude of Code Types such as: Bill Type, Bed Type, diagnosis related grouping, Provider Type, etc.

User Defined System Generated Events

User-defined System Generated Events allow limited customization by defining situations that will trigger an Event. These Events can then be used to drive automated processes, such as Workflow, Reports and Correspondence.
Event Groupings are established and the selection of modules and fields are made from a system-defined list. Start and End values can filter specific responses. Events can be set up for a specific business segment.

- Field Event Modification creation can be set up to trigger an Event when a User-defined field is modified

Schedule 1
System Features and Function

- Specific Value Event Creation can be set up to trigger an Event when specific User-defined values are added to a field, and the new value falls within the specified range
- Letter and Report Generation based on User-defined events

Workflow

Workflow functionality provides a means to automatically route tasks directly to the Users responsible for working on them, ensuring that tasks move at an efficient pace, and that they are completed in the prescribed order.
Once a User evaluates a Workflow item, it can be:

- Forwarded to another User
- Closed
- Notification can be sent, or
- Any combination of the above

Workflow items can be system-generated or manually created by Users. Items are configured from drop-down lists of system-defined types, system-defined actions and User-defined Codes. The due date is configured and a status, confidentiality level, owner and priority are selected.
Internal system attachments can be added to a Workflow item. These attachments, when displayed, provide a hot link directly to the item. Types of workflow include:

- AC200
- HC200
- Medical Claims
- Hospital Claims
- Customer Services
- Members
- Risk Management
- Pre-Existing
- Referrals
- Authorizations

Benefits

Monument Systems *xpress*™ supports the adjudication of Claims through the definition of Benefit Packages, Riders, Accumulators, Definitions, Benefits, Options, and Rules, including non-covered Benefit Rules.

Benefit Rules

- Co-payments, deductibles, co-insurance, maximums and limitations for Benefit Packages can vary by:
    - Procedure Code
    - Revenue Code

Schedule 1
System Features and Function

- DRG
- Bill Type
- Bed Type
- Op Code
- Modifier
- Location
- Provider Network
- In/Out-of-Area Indicators
- Service Codes
- Hospital ID
- Hospital Specialty
- Provider ID
- CAP Hospital Flag
- Specialty of Rendering or Referring Physician
- Provider Contract Status (Participating, Contracted or Non-participating)
- Relationship Code
- Member Gender
- Member Age, and
- Whether the Provider is the Member's PCP or not

Benefit Options can be calculated based on the billed, paid or allowed amount of the Claim.
Benefits can also be configured utilizing a Tiered Benefit Structure. Benefits can be attached directly to a Package or a Rider, which in turn is attached to a Benefit Package. Multiple Riders can be attached to a Benefit Package. Benefits within each Rider can share Accumulators. Each package and Rider can have services designated as non-covered. Any defined Package and Rider combination can be assigned to a Group to which Members can then be attached.

Benefit Options

Copay/Coinsurance and Associated Accumulators and Limits, including appropriate copay application based on the rendering physician type/specialty. Functionality afforded by this design allows the adjudication of the following Benefit Structures:

- Fixed Copay
- Tiered Copay
- Fixed Family and Member Deductibles
- Tiered Member Deductibles
- Fixed Family and Member Out-of-Pocket Maximums
- Max Dollar Limits
- Max Visit Limits
- Daily Visit Limits

Schedule 1
System Features and Function

Employer Groups

Monument Systems *xpress*™ allows a Licensee to administer Employer Groups and other groupings of Members by setting up entities to which Packages of Benefits and Rates can be attached.

Benefits are administered for Members that do not belong to a formal Employer Group (i.e. Direct Pay, Medicare, Medicaid) by assigning those Members to "pseudo" Groups (i.e. not a Direct Pay group, Medicare, Medicaid). Members can be further organized within Groups by dividing them into Divisions, Regions and Subgroups.

Benefit Packages can be created for each Group. These Benefit Packages are available to Members assigned to the Group and can vary by Division, Region, Subgroup, Carrier, Product, and Line of Business. Tight integration with the AR Module allows rates to be attached to Tier Codes for each Rider in a Benefit Package, allowing premiums to vary by Benefit Package/Rider/Tier Code combinations.

Premiums can be totaled and subtotaled at the Group, Subgroup, Division, or Region level. AR accounts are created when the Group is posted or when Members are added into a Direct Pay Group.

Historical integrity of Benefit Packages and Rates is maintained by generating a new contract line for each Benefit Package each contract year. The Licensee can decide whether to roll over Groups and the Members within each Group and Benefit Packages, at the end of each contract year.

Members can be reassigned automatically to new Benefit Packages utilizing the Member Reassignment Screen. Specific Group functionality includes:

- Multiple Business Entities for a Group
    - Division
    - Region
    - Subgroup
    - Carriers
    - Lines of Business
    - Products
    - Benefit Packages
- Tier structures to define premium billing rates for each family
    - Rates assigned at the tier level within each rider
    - Age/Gender Rating
- Billing Methods
    - Group
    - Division
    - Region
    - Subgroup

Schedule 1
System Features and Function

  - Direct Pay
- Annual group / benefit package rollovers
- Mass group terminations
- Group confidentiality
- Mass Member Rollovers within Groups
- Group Member benefit package reassignment
- Pend Functionality
  - Hard Pend holds all claims for members attached to a group for review.
  - Soft Pend flags all claims for review but pays.
- Paid-through-date Functionality
  - Prevents payment of claims with dates of service for which no premium has been paid.
- Group Events
- Group Diary
- Separate Group and Remit to Addresses
- Pre-Existing Rules and Bundles

Physicians

Provider contracting supports contractual arrangements based on multiple Networks, Carrier's products, and lines of business for a single Provider Identification Number. The Fee Schedules, Capitation Contracts, and timely filing are set up by the Network, Carrier Product, and line of business.

The Provider Contracting System is one of the primary systems referenced by all other systems for Provider information. Information about Physicians and other non-institutional Providers is stored in the Physicians module, while information about institutional Providers is stored in the Hospitals module.

Basic functions supported include:

- Supports multiple contractual arrangements by business Segment and Fee Schedules
- Setup of Physicians by Medical Group
- Supports NPI (National Provider Identifier)
- Supports Tax ID at Provider, Group, and Vendor levels
- Supports Provider Groups in addition to individual Physicians
- Support of Physicians assignment to vendors for check roll-up
- Management of multiple office locations
- Support of Primary Care Providers at the system contract level

Schedule 1
System Features and Function

- Maintenance of multiple Specialties
- Maintenance of multiple Languages
- Maintenance of Ethnicity
- Maintenance of Religion
- Recording of Physician office hours and email address
- Maintenance of credit balances to manage take backs
- Identification of Physicians associated with 'Referral Circles', the providers of which do not require referrals from each other
- Management of Provider relationships by business segment
- Allows Associations of Hospitals and Providers for viewing
- Ability to update PCP accepting status for new patients.
- Management of Network affiliations
- Management of Carrier affiliations
- Event tracking for items such as Provider and Provider Group tax identification history
- Diary to track pertinent information
- Ability to copy existing Provider record to create new Providers
- Ability to generate1099-MISC hard copy and electronic files compliant with IRS format requirements

Provider Profile administers panel size, age and gender components, and allows for multiple medical identification numbers. Additionally, backup Providers can be associated with each Provider to facilitate the handling of payment to the on call Provider when the Provider is not servicing Patients. Provider credentialing maintains a record of medical credentials, including multiple State licences and multiple Board Certifications, malpractice insurance and limits, primary medical education including residency, and continuing medical education.

Hospitals / Facilities

The Hospitals module supports contractual arrangements based on multiple Networks, Carrier's products and lines of business for a single Hospital Identification Number. The Fee Schedule, Capitation Contracts and timely filing are set up by the Network, Carrier, product and line of business. In addition, QPSP (Quick Pay/Slow Pay) Schedules, Capitation Contracts and Credentialing Data can be associated with the Hospital. Definitions by Hospital for Specialties and Preferred Correspondence Methods, as well as remit to addresses, are also available.

Contracts

Contracts can be varied by:

- Network
- Product
- Business
- Carrier
- Contract types

Schedule 1
System Features and Function

- Fee for Service
  - Defined by Fee Schedules, along with Carrier, Network, business and product
  - Date sensitive
- Capitation
  - Defined by capitation contracts by carrier, network, business and product
  - Date sensitive
  - Defined by network selection of member

- Timely Filing by Contract can be setup to notify the User with a Warning Message, Error, or does nothing option depending upon Client-defined Global Options
- Event Tracking allows System and User-defined categories and Events for reporting and searching
- Supports NPI (National Provider Identifier)
- Supports Tax ID
- Management of Credit Balances by Payor
- Diary allows free text that is date and time stamped, along with the User who added the information.
- Ability to generate 1099-MISC hard copy and electronic files compliant with IRS format requirements

Enrollment

The Enrollment Module supports enrollment of both Group and individual membership. Maintained interactively, it provides eligibility information and a variety of Enrollment Reports.

The Enrollment function allows you to manage Members enrolled in Groups, including those Members with direct pay accounts. Membership Records are maintained for both current and historical data.

Membership information includes:

- Group
- Network
- Carrier
- Tier Level
- Structure Level such as Division, Region, Subgroup
- Benefit Package,
- Direct Payment Information
- General Remarks
- Family ID (up to 10 alpha numeric characters)
- Member Suffix
- Name
- Benefit Pointer to selected benefits in Group
- Multiple Addresses

Schedule 1
System Features and Function

- Relationship code
- Gender
- Birth date
- Effective date of eligibility period
- Termination date of eligibility period
- Primary Care Provider
- Network
- Effective date of Primary Care Provider/network assignment
- Termination date of Primary Care Provider/network assignment
- Termination Reason
- Alternate Primary Care Provider or assigned Capitated Hospital (Site option)
- Social Security Number
- Numerous client site defined ID numbers
- Pend Code
- User Defined Extended Attributes
- Ability to store various member demographics
    - Ethnicity
    - Language
    - Citizenship
    - Disability
    - ESRD Status
    - Handicap
    - Marital Status
    - Smoker
    - Religion
    - Medicare
    - Medicare Low-Income Subsidy
    - Student Status
    - Employment Status
- Generation of Member or Family ID Cards
    - ID Cards and reports are custom development and will be done pursuant to a Statement of Work at a Time-and-Materials Rates.
- Event tracking with System and User-defined categories and Events that can be used when performing searches or for User-defined Events and Event categories.
- Diary allows free text that is date and time stamped along with the User who added the information
- Move a Member allows you to move data associated with an incorrectly entered Member number to the correct Member number. Thus, if Claims, Referrals, Authorizations, or other activity have incorrectly been associated with the wrong Member number, they can be moved to the correct number

Schedule 1
System Features and Function

- Member Consent allows you to capture if the member provides permission or revokes permission to share his personal information to member-assigned designees in a specific timeframe.
- Assignment to a Member of:
    - Risk Management Class with user-defined categories and levels
    - Member Confidentiality with lock out capability for users who do not match or exceed member confidentiality levels
    - Dual Enrollment allows members to be enrolled in up to two benefit plans offered by the same group
    - The Additional Coverage screen supports a cross-reference for two different member IDs.
- Coordination of Benefits
    - The COB function maintains and correlates insurance information for Members who are covered by more than one policy.
    - Functions include the ability to:
    - Enter additional insurance information
    - Track information about the insured for each Policy, including employer information
    - Specify which Members are covered by additional policies
    - Enter and calculate COB at the procedure level of the Claim when the COB amount is entered on the Claim
    - Maintain COB savings accrual

Member History

- The Member History function provides access to the history for a Member or Family and includes:
- Benefits: ability to load data in order to view member's benefit plan details including benefit, service type, prior auth requirements, copays, and any limits or special considerations.
- Enrollment History
- Call History Medical Claims
- Hospital Claims
- Medical Encounters
- Hospital Encounters
- Authorizations, and
- Referrals
- A History search may be performed by dates
- The Benefits Tab shows the Member liabilities and benefit accumulation associated with Claims that are in process and have been paid for each benefit service line associated with the Member's benefit plan.
- Calculate premium and capitation adjustments for retroactive changes.

Schedule 1
System Features and Function

Customer Services

The Customer Service Module supports tracking of calls from Members, Group, Providers, Hospitals, prospective Members and prospective Groups. It also maintains Member grievances. Information about the caller is displayed on the screen once the caller has been identified, along with call history, risk and grievence flags.

The reasons for the call and any actions taken as a result may be selected from a User-defined dropdown list. Based on the Reason Code and Action Code, scripting can be set up to prompt Users of the actions to be taken, or questions that should be asked. The explanation of the Reason and Action may be modified. The date and time when the call is opened and closed is automatically logged when the call Record is opened or closed. System generated Events, correspondence, or Workflow items can be set up based on the Reason and Action Codes for the calls.

In addition to the above items:

- A Record of Events resulting from Event Rules is maintained on the Events Tab
- Call Forwarding capability through the use of Workflow
- Immediate PCP updates
- Important comments or information about the call and the caller may be securely stored in the Diary
- Access to Member History
- Diary allows free text that is date and time stamped along with the User who added the information

Referrals

Within Monument Systems *xpress*™ , the Referral System maintains referrals for use in claims adjudication. Referrals are entered independently of the Claims and are associated with Claims at the time of manual entry or during Batch Processing.

When Claims are tied to Referrals, a Referral Number is inserted into the Claim Referrals linked to Claims provide a display box that indicates the Referral has Claims associated with it. In addtion to a display box, the system supports entry of requested and approved services. Visits taken are then updated with a Batch Process, if manual assigment of the Referral and taken visits has not been used. This feature also results in Pending or Denial of Claims based on approved and taken visits.

The Referral System calculates cost estimates based on the Provider Contract. Notification of grievances, Case Management, and Risk Management affecting the Referral are displayed based on Event triggers. A historical record of Events affecting the Referral is maintained, as well as a Diary to store all pertinant clinical information about the case.

When a Referral results in a Hospital admission, information from the Referral may be used to create an authorization:

- Referral to Physician / Hospital Tracking

Schedule 1
System Features and Function

- Review Types: Concurrent, Prospective, Pre-Determination, and Retrospective
- Copy Functionality allows Clients to copy existing Referrals without re-typing the data
- Creation of Authorization from Referrals links the Referral and Authorization together, as well as pre-populates some key elements such as Member and dates
- Estimation of Costs computes the cost of approved services for the referred to Provider based upon the Members Network, Carrier, Product and Business
- Diary allows unlimited free text that is date and time stamped, along with the User who added the information
- Claims Instructions allows free text instructions to be entered on the Referral that will automatically display on the Claim when the Claim is linked
- Event tracking with System and User-defined categories and Events that can be used when performing searches, or for User-defined reporting requirement

Authorizations

Monument Systems *xpress*™ tracks precertification, admit and discharge dates, and status on a single Record. This keeps all relevant information together and makes the authorization process as easy as possible. Cost estimates can be automatically calculated based on the Provider Contract for services rendered. Optionally, maternity and newborn tracking may be performed.

Claims may be linked to an Authorization Record, allowing information from the Claim and the Authorization to be shared. When Claims are tied to Authorizations, a display box on the Authorization will indicate there are Claims associated with the Authorization. Additionally,the number of days allowed by the Authorization are verified during the Claims process, and the Authorization is automatically updated to reflect the days used by the Claim.

Authorizations allow for:

- Pre-certifications and admissions dates and status
- Review Types: Concurrent, Prospective, Pre-Determination, and Retrospective
- Estimated cost management based on Provider's Contract
- Diary allows unlimited free text that is date and time stamped, along with the User who added the information
- Event tracking with System and User-defined categories and Events which can be used when performing searches, or for User-defined reporting requirements
- Copy functions
- Multiple services
- Extended days logging.
- Claims instructions allow free text instructions to be entered on the Authorization that will automatically display on the Claim when the claim is linked

Medical Fee Schedules

Providers may contract to be paid from a specific Fee Schedule because Monument Systems *xpress*™ keeps Fee Schedules as separate Records. Fee Schedules may be unique to a single

Schedule 1
System Features and Function

Provider, or may apply to multiple Providers or Provider Groups.

Some common sources for Fee Schedules are individual Provider Contracts, local plan-defined Fee Schedules developed from Contract or State studies, McGraw-Hill Value UnitSchedules, or Medicare RBRVS (Resource Based Relative Value Scale) Schedules.

Copies of full or partial Fee Schedules can be done easily within *xpress*™. Multiple types of payment algorithms can be combined within a Fee Schedule.

The algorithms allowed within *xpress*™ are:

- Percent of billed charges
- Percent of billed charges up to allowed amount
- Anesthesia
- By report pricing
- Relative values
- ASC (Ambulatory Surgical Center) groupers
- Pricing by location and age
- Default pricing
- Withhold schedules
- Pricing by CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) codes and RBRVS (Resource-Based Relative Value System)
- Case rates
- Case plus
- Day
- Day plus
- GPCI (Geographical Practice Cost Index) pricing

Hospital Fee Schedules

Hospital Fee Schedules may be set up for each facility based on contractual agreements for payment.

For each Bed Type and Location, a compensation method is selected indicating whether fees are based on a specific rate and how that rate may be applied - on a percentage of billed charges, DRG (Diagnosis Related Groups), or per diem. Multiple types of payment algorythms can be combined within a Fee Schedule.

The algorythms allowed within *xpress*™ Hospital Fee Schedules are:

- Pricing by DRG (Diagnosis Related Groups)
- Flat fee
- Percent of billed
- By Report
- Case rates
- Case plus
- Medical Fee Schedules
- Per diems

Schedule 1
System Features and Function

- Tiered days – Rates
- ASC (Ambulatory Surgical Center) Groupers
- "Lesser of" pricing
- Fixed Fee not to exceed Percent of Billed Charges
- Fixed Fee not to exceed Billed Charges
- Day
- Day plus

Hospital and Medical Claims

The Monument Systems *xpress*™ Claims System performs online and batch adjudication of professional and institutional Claims. Claims, whether entered in batch or online mode, may be edited prior to final adjudication. Claims suspended for review by the adjudication edits can be released for payment, modified, or denied. Additional options include the ability to display and print a list of open batch numbers using 3 sorting options.

The Claims and Medical Management Systems are integrated in 2 ways:

1. A Claim will auto-adjudicate based on the status of the corresponding Referral or Authorization, and
2. Claim-specific remarks entered on an individual Authorization or Referral can be populated on the corresponding Claim to assist the Claims Processor in adjudicating the Claim in accordance with the medical management decision. This integration allows for the appropriate services to be paid in a timely fashion.

Medical Claims

- Manual data entry and electronic entry
- Online and batch adjudication
- Encounter manual entry and adjudication
- Event tracking with System and User-defined categories and Events, which can be used when performing searches, or for User-defined reporting requirements
- Diary allows unlimited free text that is date and time stamped along with the User who added the information
- Coordination of Benefits amounts can be entered on a Claim
- Member reimbursement including the ability to enter a claim with a member as payee, to have the claim permanently recorded and retrievable in the system, and to have the ability to finalize the member reimbursement with the creation of a check and an EOP/remittance advice.
- Clean / Unclean Claim Tracking
- Referral / Authorization linkage
- Ability to check paid-through-dates for Groups and/or Individuals and prevent Claims payment where dates of service are beyond the paid-through-date

Schedule 1
System Features and Function

Hospital Claims

- Manual data entry in the UB92 or UB04 format
- Online and batch adjudication
- Event tracking with System and User-defined categories and Events, which can be used when performing searches, or for User-defined reporting requirements
- Diary allows unlimited free text that is date and time stamped along with the User who added the information
- Coordination of Benefits amounts can be entered on a Claim
- Member reimbursement
- Clean/Unclean Claim Tracking
- Referral/Authorization linkage
- Ability to check paid-through-dates for Groups and/or Individuals and prevent Claims payment where dates of service are beyond the paid-through-date

Finders

Monument Systems *xpress*™ offers a variety of search features for locating information. Within each functional area the Find tab is utilized to perform searches for records meeting specific criteria.
Users may also perform searches for required codes from some textboxes. Within many areas of the program, when a user needs to reference a provider code, diagnosis code, member code, etc., they can search for the code needed and, often, have the code automatically returned to the textbox requiring it.
Separate from the Find tab, Monument *xpress*™ has special search features, including Claim Finder, Physician Finder, and Member Finder, which expands the search capabilities using additional data elements and allowing multiple data elements within the search.

Correspondence

Monument Systems *xpress*™ allows the Licensee to create their own correspondence templates using Crystal Reports, which can then be merged into the base set of Reports offered by Monument Systems *xpress*™. Letters can be printed on demand, or may be scheduled to run at specific times when printers are in less demand such as at night or in off-hours.

- Letters can be printed on demand or in batch production
- Letters are maintained as Crystal Reports that are customized by the Licensee

Reports

Monument Systems *xpress*™ will deliver a set of Standard Reports with *xpress*™. The Licensee has the ability to tailor the Standard Reports to meet their business requirements using Crystal

Schedule 1
System Features and Function

Reports. The reporting module included with Monument Systems *xpress*™ allows the Licensee to generate System Reports automatically or upon request.

In addition, the Licensee can create Custom Reports with custom parameters and append those into the system. Specific Users can be given access to System and Custom Reports through the Security Module. Both System and Custom Reports can be printed to any system printer, can be emailed, faxed or printed to the screen.

In addition, all Reports can be printed immediatley, at a later time and date, or scheduled to run on a periodic basis. Monument Systems *xpress*™ is also capable of scheduling the same Report with varing parameters to run on a periodic basis.

See the Standard Reports List for the current list of reports supported by Monument Systems *xpress*™.

Optional Modules

Electronic Commerce

Monument Systems *xpress*™ *3.10* supports current standard HIPAA (Health Insurance Portability and Accountability Act) transactions, provided through the appropriate Electronic Data Interchange interface.
Monument Systems *xpress*™ also supports GEI Inbound files, General Eligibility Interface

Case Management (Case Tracking)

The Monument Systems *xpress*™ Case Tracking (Case Management) Module stores information about Patient cases. Tracking features include:

- Maintenance of a History of Providers
- Diagnoses
- Procedures
- Prescriptions
- Actions, and
- External managers associated with a case

An Event History and a Diary for the Case Record provide additional tracking tools. Members with Case Management are identified using the Monument Systems *xpress*™ Case Tracking System. Members with a Case Management Record will have a Case Management Flag displayed in the core modules. Viewing the details of a Member's case can be performed quickly and easily by double-clicking on the Case Management Flag associated with the Module.

- User-defined Codes include:

Schedule 1
System Features and Function

  - Problem Codes
  - Action Codes
  - Outcome Codes
  - Contact Codes

- Case Manager
- Diary allows unlimited free text that is date and time stamped along with the User who added the information
- Event tracking with System and User-defined categories and Events that can be used when performing searches or for User-defined reporting requirements
- Potential Case Triggers is a rule-based module that allows Client to define criteria for designated problems.

  Each rule can be varied by Business segment (Network, Carrier, Product and Business)
  Once the Rules are defined, the Client can run the CT100 Report that will search Medical and Hospital Claims Referrals and Authorizations for items that meet the criteria
  A new case can be created to record the problem or the process will add the problem to the existing case
  Events are added to the item to Record processing

Premium Billing / Accounts Receivable

Monument Systems *xpress*™ premium billing and Account Receivable system supports billing to Employer Groups at the Group, Division, Region, or Subgroup level and individuals. Groups can be aggregated and billed in cycles allowing for Groups to be specified to receive premium bills in cycles. Tier Codes define the Rules to auto-calculate the Tier Code at the Member or Family level. The rules can be varied by multiple member attributes.

The Premium Billing Module allows for running trial runs and producing Reports to identify possible billing errors before running the actual premium billing. Premium rates are calculated for each subscriber from the rates attached to Riders in the Benefit Package to which that subscriber is assigned, or by manual rate insertion on the Member Record. Auditable historical Premium Records are stored for each subscriber allowing changes in enrollment to automatically create retroactive premium adjustments, when necessary.

Monument Systems *xpress*™ is an open-item system and allows the recording of payments received at the Group level. Payments can be applied to open items at the subscriber level enabling a process that performs enrollment and premium reconciliation. Premium billing functionality is integrated within
Monument Systems *xpress*™ to monitor Claims for Members attached to Groups who have not paid their premium - allowing Claims for those Members not to be released until payment is received.

Schedule 1
System Features and Function

Functionality included in the Accounts Receivable Module includes:

- Combined Group / Direct Pay Premium Billing
    - Monthly
    - Controlled by Direct Pay Data attached to the Subscriber
- Post/Pre-Bill Options
    - Bill by Cycle(s) or Employer Group(s)
- Electronic Funds Transfer
    - Bank Drafts from Direct Pay Bank Accounts
    - Supported by Third Party Tool
    - Lockbox
        - Electronic File submitted by Bank
        - Health Maintenance Organization Accounts Receivable Account Number
        - Check Number
        - Account Name
        - Check Date
        - Check Amount
- Reconciliation of Full and Partial Payments
    - Automatic reconciliation applies to oldest open item(s) until all cash is applied
    - Manual reconciliation user determines which items to close with selected cash
- Payments and related Adjustments
    - Non Sufficient Funds
        - Reverses closed to open items
        - Deletes unapplied cash
        - Flags check as Non Sufficient Funds
        - Reports back on next Statement
    - Voids
        - Reverses Closed to)pen items
        - Deletes unapplied cash
        - Flags check as void
    - Undo
        - Reverses applied payments
    - Reimbursement
        - Reimbursement adjustments can be processed and referenced to any unapplied payment
    - Distributions

Schedule 1
System Features and Function

- Payments can be distributed from and to multiple accounts

- Adjustments
  - Manual Adjustment Debits or Credits with User-defined remarks
  - Bad Debt Adjustments and Bad Debt Reversals
  - System captures real-time retro Member additions, terminations and changes in conjunction with the Employer Groups pro-ration schedule

- Reporting
  - Trial Balance
  - Aged Trial Balance
  - Earned Revenue
  - Unearned Revenue
  - Prepaid Accounts

- Event Tracking