



HEALTH PLAN MANUAL

Part III – Reporting Guidance

Department of Human Services, Med-QUEST Division

October 2026

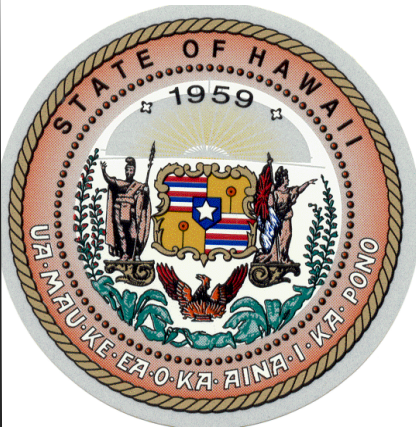


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PRODUCTION STATUS

Background

Med-QUEST Division (MQD) formally released a revised Quest Integration (QI) and Community Care Services (CCS) reporting package in July 2021 and subsequently provided technical assistance to QI and CCS Health Plans to implement the new managed care reporting requirements. In July 2022, MQD hired a contractor to assist with improving data quality for the purpose of moving reports into production. Through a series of efforts including presentations, group-based technical assistance, questions and answers, and individualized assistance, MQD has worked with QI and CCS Health Plans to transition reports from “pilot” into “production.” To be effective, MQD has collaborated with its contractor to distribute reports into waves, to provide intensive support on reports by wave to enable MQD to move reports into “production,” and keep QI and CCS Health Plans informed on reports that MQD intends to move into production imminently.

“Production” indicates that MQD has determined that Health Plans have understood the intention of the report and report fields; sufficient technical assistance has been provided to ensure data quality; Health Plans have been provided the new data quality assurance tools and strategies prior to submitting the report to MQD; and an evaluation of the incoming reports from the majority of the plans indicates that the report is accurate. A report in production is no longer in a “pilot” stage, and MQD anticipates making minimal to no content changes on the report. Once the report is in production, it will continue to be evaluated against data quality metrics and subject to escalation if data standards are not met.

In 2025, MQD created a Health Analytics Program to improve the reporting process for Health Plans and MQD staff. The Health Analytics Program (HAP) Health Plan Portal will allow Health plans to submit reports via a portal that will check data quality at the time of submission. Following acceptance of data quality, the portal will automatically calculate KPIs. The portal will notify the Health Plans of the status of each submitted report, allow Health Plans to download submitted reports, and observe a KPI dashboard with historical data for each report.

List of All Reports

Report Section	Report #	Report Name	Abbr.	Reporting Frequency	Submission Type	Reporting Period(s)	Due Date
Administration, Finances, and Program Integrity	101	Disclosure of Business Transactions and Ownership	ABT	Annually, Ad hoc	Manual	1/1-12/31	10/31 of proceeding year (Annual) Within 30 days of change in ownership (Ad hoc)
Administration, Finances, and Program Integrity	102	Medicaid Contract	MCR	Annually	Manual	7/1-6/30	12/31
Administration, Finances, and Program Integrity	103	Overpayments	OPR	Monthly, Annual, Ad Hoc	Manual	1/1-1/31, 2/1-2/28, 3/1-3/31, 4/1-4/30, 5/1-5/31, 6/1-6/30, 7/1-7/31, 8/1-8/31, 9/1-9/30, 10/1-10/31, 11/1-11/30, 12/1-12/31 1/1-12/31 (annual)	The last day of each proceeding month (monthly) Within 60 days of identifying overpayment from DHS to health plan (Ad hoc) 3/31 of proceeding year (annual)
Administration, Finances, and Program Integrity	104	Encounter Data/Financial Summary Reconciliation	EDFS	Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	12/31, 3/31, 6/30, 9/30
Administration, Finances, and Program Integrity	105	Medical Loss Ratio	MLR	Annually	Manual	1/1-12/31	10/31 of proceeding year
Administration, Finances, and Program Integrity	106	Fraud, Waste, and Abuse	FAS	Quarterly	Portal	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31

Administration, Finances, and Program Integrity	107	Prescription Drug Rebates	PDR	Monthly, Annually	Manual	1/1-12/31 (Annually)	January - March DUE: 4/22 April - June DUE: 7/22 July - September DUE: 10/22 October - December DUE: 1/22 7/31 (Annually)
Administration, Finances, and Program Integrity	108	QUEST Integration Financial	QFG	Quarterly, Annually	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30 (Quarterly) 1/1-12/31 (Annually)	10/31, 1/31, 4/30, 7/31 (Quarterly) 10/31 of proceeding year (Annually)
Administration, Finances, and Program Integrity	109	Third Party Liability Cost Avoidance	TPL	Monthly, Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30 (quarterly)	The last day of each proceeding month (monthly)
Covered Benefits and Services	201	Community Integration Services Plus	CIS+	Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31
Covered Benefits and Services	202	Early and Periodic Screening, Diagnostic, and Treatment	EPSDT	Quarterly, Annually	Manual	10/1-9/30, 1/1-12/31, 4/01-3/31, 7/1-6/30 (Quarterly) 10/01 - 9/30 (Annually)	10/31, 1/31, 4/30, 7/31 (Quarterly) 2/28 of the proceeding year (Annually)
Covered Benefits and Services	204	Going Home Plus	GHP	Quarterly, Semi-annually	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30 1/1-6/30, 7/1-12/31	10/15, 1/15, 4/15, 7/15 (Quarterly) 1/15, 7/15, (Annually)
Covered Benefits and	205	Health Coordination	HCS	Quarterly	Manual	7/1-9/30, 10/1-12/31,	10/31, 1/31, 4/30, 7/31

Services		Services				1/1-3/31, 4/1-6/30	
Covered Benefits and Services	206	Community Integration Services Plus (CIS+) Medical Respite	MRR	Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31
Member Services	301	Interpretation/ Translated Documents	ITR	Quarterly	Portal	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31
Member Services	303	Call Center Report	CCR	Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31
Member Services	304	Member Grievance and Appeals	MGA	Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31
Provider Network / Services	401	Provider Grievance and Claims	PGC	Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31
Provider Network / Services	402	Value Driven Health Care	VHC	Annually	Manual	1/1-12/31	10/31 of proceeding year
Provider Network / Services	403	Provider Network Adequacy Verification	PNA	Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31
Provider Network / Services	404	Suspensions, Terminations, and Program Integrity Education	PIE	Quarterly, Ad hoc	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30 (Quarterly)	10/31, 1/31, 4/30, 7/31 (Quarterly) Within 3 days of suspension/ termination event (Ad Hoc)
Provider Network / Services	405	FQHC/RHC Services Rendered	FQHC	Annually, Quarterly	Manual	1/1-12/31 (Annually) 7/1-9/30, 10/1-12/31, 1/1-3/31,	5/31 of proceeding year (Annually) 11/30, 2/28, 5/31, 8/31

						4/1-6/30 (Quarterly)	(Quarterly)
Provider Network / Services	406	Timely Access	TAR	Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	11/30, 2/28, 5/31, 8/31
Provider Network / Services	407	Hospital Closure Report	HCR	Ad Hoc	Manual	1/1-12/31	Ad Hoc
Quality	501	Accreditation Status	ASR	Annually, Ad Hoc	Portal	1/1-12/31	7/1 of proceeding year (Annually) Within 7 days of change in status (Ad hoc)
Quality	502	Health Disparities	HDR	Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31
Quality	503	Performance Improvement Projects	PIP	Annually, Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30 1/1- 12/31	10/31, 1/31, 4/30, 7/31 (Quarterly) 1/31 (Annually)
Quality	504	Quality Assurance and Program Improvement	QAPI	Quarterly	Portal	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31
Quality	505	Adverse Events	AER	Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31
Utilization Management	601	Primary Care	PCR	Annually	Portal	1/1-12/31	10/31 of proceeding year
Utilization Management	602	Drug Utilization Review	DUR	Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	11/30, 2/28, 5/31, 8/31
Utilization Management	603	Prior Authorizations – Medical	PAM	Quarterly	Portal	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31

Utilization Management	604	Prior Authorizations – Pharmacy	PAP	Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31
Utilization Management	605	Mental Health and Substance Use Disorder Parity	MHS	Annually	Manual	1/1-12/31	5/31 of proceeding year
Utilization Management	606	Over-Utilization and Under-Utilization of Services	OUS	Quarterly	Portal	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	10/31, 1/31, 4/30, 7/31
Utilization Management	607	Provider Preventable Conditions	PPC	Quarterly	Manual	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	11/30, 2/28, 5/31, 8/31

Reports and KPIs Newly Moving to Production

This section is reserved for Reports and KPIs that have undergone the report/KPI improvement process and have been deemed ready for production by MQD. These reports/KPIs will be subject to escalation for data quality and performance.

Reports and KPIs Newly Moving to Production						
Report Name	QI	CCS	Frequency	Production Date for KPIs	Production for Data Quality	New KPIs in Production & Benchmark
PNA	X	X	Quarterly	10/1/2026	7/1/2024	<i>Minimum Number of Network Providers: KPI #1-25</i> <i>Maximum Time to Travel: KPI #1-19</i> <i>Provider to Enrollee Ratio: KPI #1-3</i> <i>Health Plan Responses to Unmet KPIs: KPI #1: Yes</i>
TAR	X	X	Quarterly	10/1/2026	10/1/2023	<i>Appointment Wait Times</i> KPI #1: ≥60% KPI #2: ≥80% KPI #3: ≥60% KPI #4: ≥60% KPI #5: ≥60% KPI #5: ≥1 <i>Health Plan Responses to Unmet KPIs: KPI #1: Yes</i>

Reports Moving to the Health Analytics Program (HAP) Health Plan Portal

The reports listed below have undergone the development process to be added to the HAP Health Plan Portal. These reports will be submitted via the HAP Health Plan Portal beginning 1/1/2027.

Reports Moving to the HAP Health Plan Portal		
Report Name	Submission Type	Frequency
Call Center Report (CCR)	Portal	Quarterly
Performance Improvement Projects (PIP)	Portal	Quarterly, Annually
Medicaid Contract Report (MCR)	Portal	Annually

The reports listed below are submitted through the HAP Health Plan Portal.

Reports Moving to the HAP Health Plan Portal		
Report Name	Submission Type	Frequency
Accreditation Status (ASR)	Portal	Annually
Fraud, Waste, and Abuse (FAS)	Portal	Quarterly
Interpretation/Translated Documents (ITR)	Portal	Quarterly
Over and Under Utilization of Services (OUS)	Portal	Quarterly
Prior Authorizations – Medical (PAM)	Portal	Quarterly
Primary Care (PCR)	Portal	Annually
Quality Assurance and Performance Improvement (QAPI)	Portal	Quarterly

Reports and KPIs Currently in Production

Below is the running list of all reports and KPIs currently in production, including any newly added reports.

Reports and KPIs in Production							
Report Name	QI	CCS	Type	Frequency	Production Date for Data Quality	Production for Data Quality	KPIs in Production & Benchmark
Accreditation Status (ASR)	Y	Y	Portal – 10/31/2025	Annually, Ad Hoc	10/1/23	Y	KPI #1: Yes KPI #8: Yes KPI #9: Yes
Adverse Events Report (AER)	Y	Y	Manual	Quarterly	1/1/2024	Y	
Call Center Report (CCR)	Y	Y	Manual	Quarterly	10/1/23	Y	Member Call Center: KPI #1: ≤ 1 per 100 KPI #2: ≤ 5 per 100 KPI #3: 85% or higher KPI #4: 4 minutes or less

							<p>KPI #5: 30 seconds or less</p> <p>Member Nurse Line: KPI #1: ≤ 1 per 100 KPI #2: ≤ 5 per 100 KPI #3: 85% or higher KPI #4: 4 minutes or less KPI #5: 30 seconds or less</p> <p>Provider Call Center: KPI #1: ≤ 1 per 100 KPI #2: ≤ 5 per 100 KPI #3: 85% or higher KPI #4: 4 minutes or less KPI #5: 30 seconds or less</p>
Community Integration Services Plus (CIS+)	Y	Y	Manual	Quarterly	10/1/2024	Y	
Disclosure of Business Transactions and Ownership (ABT)	Y	Y	Manual	Annually, Ad hoc	10/1/23	Y	
Drug Utilization Review (DUR)	Y	Y	Manual	Quarterly	10/1/2024	Y	
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Y	N	Manual	Annually, Quarterly	1/1/24	Y	KPI #5: Yes
Encounter Data/Financial Summary Reconciliation (EDFS)	Y	Y	Manual	Quarterly	1/1/24	Y	

FQHC/RHC Services Rendered (FQHC)	Y	Y	Manual	Annually, Quarterly	1/1/24	Y	
Fraud, Waste, and Abuse (FAS)	Y	Y	Portal – 10/31/2025	Quarterly	10/1/23	Y	KPI #1: Yes KPI #2: 100% KPI #3: ≥25%
Going Home Plus (GHP)	Y		Manual	Quarterly, Semi-annually	10/1/2024	Y	
Health Disparities Report (HDR)	Y	N	Manual	Quarterly	4/1/23	Y	
Interpretation/Translated Documents (ITR)	Y	Y	Portal – 10/31/2025	Quarterly	1/1/24	Y	KPI #1: 90% KPI #2: 90%
Medicaid Contract (MCR)	Y	N	Manual	Annually	9/1/22 (KPIs Listed Only)	Y	KPI #1: 0 KPI #2: 0
Medical Loss Ratio (MLR)	Y	Y	Manual	Annually	9/1/22	Y	KPI #1: 85% or higher
Member Grievances and Appeals (MGA)	Y	Y	Manual	Quarterly	1/1/24	Y	KPI #1: ≥95% KPI #2: ≥95% KPI #3: ≥95% KPI #4: ≥95%
Mental Health and Substance Use Disorder Parity (MHS)	Y	Y	Manual	Annually	1/1/24	Y	
Over and Under Utilization of Services (OUS)	Y	Y	Portal – 10/31/2025	Quarterly	7/1/23	Y	
Overpayments (OPR)	Y	N	Manual	Quarterly, Ad Hoc	1/1/24	Y	
Performance Improvement Projects (PIP)	Y	Y	Manual	Quarterly	7/1/23	Y	KPI #1: Yes KPI #3: Yes
Prescription Drug Report (PDR)	Y	Y	Manual	Monthly, Annually	4/1/23	Y	KPI #1: 0 KPI #2: Yes KPI #3: Yes
Primary Care Report (PCR)	Y	N	Portal – 10/31/2025	Annually	4/1/23	Y	
Prior Authorizations - Pharmacy (PAP)	Y	Y	Manual	Quarterly	1/1/24	Y	KPI #1: <10%
Prior Authorizations – Medical (PAM)	Y	Y	Portal - 10/31/2025	Quarterly	7/1/23	Y	KPI #1: <10% KPI #2: <5%
Provider Grievances and Claims (PGC)	Y	Y	Manual	Quarterly	9/1/22	Y	KPI #3: 99% KPI #5: 99% KPI #7: 99% KPI #9: 99%

							KPI #11: 99% KPI #13: 99% KPI #15: 99% KPI #17: 99%
Provider Network Adequacy Verification (PNA)	Y	Y	Manual	Quarterly	7/1/2024	Y	<i>Minimum Number of Network Providers:</i> KPI #1-25 <i>Maximum Time to Travel:</i> KPI #1-19 <i>Provider to Enrollee Ratio:</i> KPI #1-3 <i>Health Plan Responses to Unmet KPIs:</i> KPI #1: Yes
Provider Preventable Conditions (PPC)	Y	Y	Manual	Quarterly	4/1/23	Y	KPI #2: 0 KPI #3: Yes
Quality Assurance and Performance Improvement (QAPI)	Y	Y	Portal – 10/31/2025	Quarterly	7/1/23	Y	KPI #1: Yes KPI #2: Yes KPI #3: Yes KPI #4: Yes KPI #5: Yes KPI #6: Yes KPI #7: Yes KPI #8: Yes KPI #9: Yes KPI #10: Yes KPI #11: Yes KPI #12: Yes KPI #13: Yes KPI #14: Yes KPI #15: Yes KPI #16: Yes KPI #17: Yes KPI #18: Yes
QUEST Integration/CCS Financial (QFG)	Y	Y	Manual	Annually, Quarterly	7/1/23	Y	
Suspensions, Terminations, and Program Integrity Education (PIE)	Y	Y	Manual	Quarterly, Ad Hoc	7/1/23	Y	
Third Party Liability (TPL)	Y	Y	Manual	Monthly, Quarterly	1/1/24	Y	

Timely Access Report (TAR)	Y	Y	Manual	Quarterly	10/1/23	Y	<i>Appointment Wait Times</i> KPI #1: ≥60% KPI #2: ≥80% KPI #3: ≥60% KPI #4: ≥60% KPI #5: ≥60% KPI #5: ≥1 <i>Health Plan Responses to Unmet KPIs:</i> KPI #1: Yes
Value Driven Health Care (VHC)	Y	N	Manual	Annually	4/1/23	Y	
Community Integration Services Plus (CIS+) Medical Respite (MRR)	Y	Y	Manual	Quarterly	4/1/26	Y	KPI #1: ≥90% KPI #2: 100% KPI #3: ≥90% KPI #8: ≥95%

GENERAL REPORTING INSTRUCTIONS

General Instructions

- A) The Health Plan shall use this reporting manual to complete and submit all reports to DHS.
- B) Each section in this manual corresponds to a report with the same name which provides detailed instructions on required information and data; methodology to complete the report; Key Performance Indicators (KPIs); and additional DHS review processes, if applicable.
- C) The HAP Health Plan Portal will be used for the reports indicated in the "Reports and KPIs Currently in Production" table above with the "Submission Type" of "Portal." Manual submissions of these reports will not be accepted.
- D) The Health Plan may be imposed a civil monetary penalty and/or liquidated damages as specified in the Contract for a late report, the Health Plan's failure to follow the specified methodology, or the Health Plan's failure to submit complete and accurate data in any report submitted to DHS.
- E) DHS may, at its discretion, require more frequent reporting by the Health Plan to provide accelerated monitoring as needed.
- F) The Health Plan shall respond to DHS's request for any follow-up, actions, information, etc. as applicable per contract section 6.5.C.
- G) Missing and N/A Logic: Please note that although missing values are permissible data entries that facilitate easier data validation, MQD may still reject reports if required data points are not provided. **Missing or N/A values on all reports, please use the logic outlined below:**

- **Numeric Data:**

- 99 = non-applicable; data that isn't there and shouldn't be there
- 999 = unknown; data that should be there but isn't known
 - Use "0" when the known data is actually "0"
 - If data is missing, use "-999", never "0"

- **Time:**

- 88:88 = non-applicable; data that isn't there and shouldn't be there
- 99:99 = unknown; data that should be there but isn't known

- **Characters:**

- NA = non-applicable; data that isn't there and shouldn't be there

“Missing” = unknown; data that should be there but isn't known

- **Dates:**

- 12/31/2200 = non-applicable; data that isn't there and shouldn't be there

- 12/31/2299 = unknown; data that should be there but isn't known

High Quality Data: In order for reports to be accepted with production quality data, they must:

- Be thoroughly completed.
 - Exact requirements are report-specific and variable specific, however the general expectation is as follows:
 - Critical fields, such as HAWI_ID must be 100% complete.
 - Fields which are required for KPI calculations must be 95% complete.
 - Fields that do not impact data integrity and still allow for KPIs to be calculated must be 85% complete.
- Align to data reference tables. All fields should be completed with valid data types that are compliant with guidance in data reference tables.
- Be accurate and consistent across reports. For example, Total Cost of Care appears across several reports and should be consistent across all reports. In addition, many reports include references to data located in other fields or tabs within the report. These references should be consistent with one another.

KPI Benchmark Guidance:

- For any benchmark greater than or equal to 15%, round to the nearest percent.
 - For example, if the benchmark is $\geq 99\%$, a plan with a result of 98.8% would round up to a result of 99% and meet this benchmark.
- For any benchmark less than 15%, round to the nearest tenth.
 - For example, if the benchmark is $\geq 10\%$, a plan with a result of 9.8% would not round up and would fail to meet the benchmark.

General Instructions for Health Analytics Program Health Plan Portal

A) The HAP Health Plan Portal will be used to submit a subset of 7 reports with all reports transitioning to this format over a period of time.

- B) The portal will notify Health Plans about data quality upon submission and calculate KPIs upon acceptance.
- C) Requesting access to portal
 - a. Health Plan users will be required to submit an access request to use the portal.
 - b. Submit your request at <https://healthdata.hawaii.gov>
- D) E-learning requirement
 - a. Health Plan users will be required to complete a one-time e-learning module that will explain the functions of the portal.
 - b. The e-learning must be completed before access to the portal is granted.
- E) The Health Plan shall complete and submit each report template using the general submission protocol listed here.
 - 1. Each report shall be titled using the format [Health Plan Name]_XXX_YYMM where XXX corresponds to the report abbreviation listed in Table 1 unless otherwise specified in a specific report's instructions.
 - 2. The reports shall be routinely submitted to DHS based on the provided reporting schedule in Table 1. If the report deadline falls on a non-working day, then the report is due the first working day after the due date.
 - 3. The "reference file" is to be removed from the report template before submitting into the HAP. If a file has multiple tabs, the tabs must be saved and uploaded to the HAP individually.
 - 4. The identified reports, as labeled as "Portal" in Reports and KPIs in Production Table under "Submission Type," shall be submitted via the HAP Health Plan Portal.
 - 5. Extension Requests must be requested at least two business days in advance. Requests must be submitted via the portal. Extension requests submitted via the portal will be approved or denied before the due date.
 - a. Steps to perform an extension request may be found here: link will be inputted here in a later version of the HPM.
 - b. For extension requests longer than two weeks, the Health Plan is to email the MQD Report Owner and copy MQDReporting@pcgus.com.

HAP Health Plan Portal Data Quality Standards

Please note below some general guidance around data quality standards for HAP Health Plan Portal report submissions:

- a. HP_ID Variable should be entered as listed below for each health plan:
 - ALOHAC
 - HMSAAA
 - KAISER
 - OHANAA
 - UNITED
- b. Column headers should omit any leading or lagging spaces
- c. Column names should match data reference table exactly
- d. Do not add or remove columns
- e. Follow the reference table exactly for acceptable values.
- f. Ensure conditional logic holds for columns that are tied to the response of another field.
- g. Ensure column data types align with the reference table.

Quantitative Data Review

The HAP Health Plan Portal automatically performs a data quality check on quantitative reports. These reports will not move through the review process until they are accepted for data quality.

- **Accept** = report passed data quality check
- **Reject** = report failed data quality check

Qualitative Data Review

Some reports are fully qualitative reviews or partial qualitative reviews. These reports or those report sections will be reviewed by the MQD reviewer for completion and quality. These reviews are still considered data quality checks.

- **Accept** = report passed data quality check
- **Reject** = report failed data quality check

Key Performance Indicators (KPI) Review

Key performance indicators (KPIs) are calculated whenever the data quality thresholds are met. The MQD Reviewer then decides to approve or deny the submission by evaluating each KPI and checking Met, Not Met or Unable to Evaluate in the HAP Health Plan Portal review tool. When evaluating whether to approve or deny a report submission, the MQD Reviewer will consider the following to make comprehensive approve/deny decisions:

- **Approve:**
 - The health plan is meeting a majority of the KPIs.
 - There is sufficient evidence to support that the health plan is meeting qualitative benchmarks.
 - The health plan is meeting quantitative benchmarks.
- **Deny:**
 - The health plan is not meeting a majority of the KPIs.
 - The health plan is not meeting a critical in-production KPI.
 - There is insufficient evidence to support that the health plan is meeting qualitative benchmarks.
 - The health plan is not meeting quantitative benchmarks

MQD Reviewer Decision

The MQD Report Reviewer will complete the decision area in the portal and approve or deny the report. A decision notification will be sent to the Health Plan's attester. The decision options are outlined below:

- **Accepted & Approved** – if the report meets both data quality and KPI benchmarks.
- **Accepted & Denied** – if the report meets data quality standards but the report is denied for not meeting performance benchmarks.

Key Performance Indicator (KPI) Phases

- **Phase 1 & 2**
 - Phase 1 & 2 KPIs are considered to be "in production" and potentially subject to remediation for non-compliance
 - Supported by clear contractual language; some include defined benchmarks
 - Certain critical KPIs (e.g., DCCA compliance/licensure, federal sanctions) require immediate remediation if not met
 - Long-standing contractual requirements (e.g., prior authorization timeliness, call center metrics, grievance timeliness) are included in Phase 2
- **Phase 3 & 4**
 - Phase 3 & 4 KPIs are not generally subject to remediation for non-compliance
 - Based on high-level contractual language or evidence-based standards
 - No specific benchmarks and/or clearly defined expectations from Health Plans

Submission Instructions for Reports Submitted to SharePoint

- A) The Health Plan shall complete and submit each report template (non-HAP) using the general submission protocol listed here.
- B) Each report shall be titled using the format [Health Plan Name]_XXX_YYMM where XXX corresponds to the report abbreviation listed in Table 1 unless otherwise specified in a specific report's manual.
- C) The reports shall be routinely submitted to DHS based on the provided reporting schedule. If the report deadline falls on a non-working day, then the report is due the first working day after the due date.
- D) All reports and supporting documentation shall be submitted electronically on SharePoint. Specific instructions can be found in the "QUEST Integration Health Plan Report Submission Standard Operating Procedure (SOP)."
- E) Extension requests must be requested at least two business days in advance. Requests must be sent via email to the MQD lead report reviewer (list can be found on each Health Plan's SharePoint page) and mqdreporting@pcgus.com. DHS must approve the extension before the due date.

Versioning and Adoption of New Versions

- A) The DHS may update any document within the reporting package including the manual, report tools, report review tools, or any embedded documents through an official amendment.
- B) Any changes, including deletions or additions, will be clearly outlined in an amendment to the Health Plan Manual or a Provider Memo.
- C) If there were no changes to any documents, then Health Plans will continue to utilize the existing report template.

DHS Review

DHS shall:

- A) Review the Health Plan's report to ensure contract compliance.
- B) Review the Health Plan's KPIs to evaluate Health Plan performance for each reporting area.
- C) Take follow-up action on any areas of concern observed in each report including any actions listed in specific reports.
- D) Health Plans will have up to 90 days from the date of release of each version of the Health Plan Manual to adopt and utilize any

new versions of documents within the reporting package. Any reports submitted after the 90 days must utilize all the latest versions of the documents. Health Plans may transition to using the new version of any report tools earlier than 90 days for manual entry reports (SharePoint reports only. This does not apply to non-HAP Health Plan Portal reports).

REPORT 101: DISCLOSURE OF BUSINESS TRANSACTIONS AND OWNERSHIP

101.1 Introduction

- A) The purpose of this report is to evaluate and monitor the Health Plan's business transactions with parties of interest including any subcontractors, if applicable, and Health Plan ownership.

101.2 Applicable Contract and Health Plan Manual Sections

- A) Section 14.7 (Full Disclosure) contains information on business relationship requirements, disclosures, and required reporting.
- B) Section 12.1.B.2.e (Compliance Plan) contains Health Plan compliance information.
- C) Section 6.2.F.3 (Disclosure of Information on Annual Business Transactions) references the current report and requirements per 41 CFR §455.104 and 42 CFR §438.230.

101.3 Terms and Definitions

- A) N/A

101.4 Methodology

A) This report is organized into three sections.

1. In **Section I: Health Plan's Business Transaction**, the Health Plan shall provide the following information annually on business transactions with specified parties:
 - a. Disclose any business transactions with a specified party as defined in the contract.
 - 1) Detailed information on these will be entered into the embedded reporting template "ABT_Worksheet_1" including costs and reasonableness justifications.
 - b. Sum of the costs associated with these business transactions. This will then be divided by the denominator budget which is found in

the Medical Loss Ratio (MLR) Report Worksheet, tab "Summary Calculation", Item 2 "denominator" in the Health Plan's most recent MLR report.

2. In **Section II: Change in Ownership**, the Health Plan shall report any changes to Health Plan ownership within 30 days and provide a narrative on these changes. If there were no changes then the Health Plan shall report "No."
3. In **Section III: Health Plan Ownership**, the Health Plan shall complete this annually and every time there is a change in Health Plan ownership (Section 2). The Health Plan shall use the embedded excel documents "ABT_Worksheet_2" to report on every individual and corporation with an ownership or controlling interest in the managed care entity.
4. The Health Plan shall use "ABT_Worksheet_3" to complete information on all managing employees, defined as the management and executive team that will oversee the contract with DHS.
5. The Health Plans shall list any individual who has ownership or controlled interest in the Health plan and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX Service.

101.5 Key Performance Indicators (KPIs)

- A) DHS shall use the following KPIs to evaluate Health Plan performance on the Business Transactions and Ownership Report.
 1. Number of business transactions: Number of business transaction with specified parties
 2. Percent of costs associated with business transactions: The numerator will be the sum of the costs associated with reported business transactions and the denominator will be the denominator calculated in the MLR report worksheet, Summary Calculation tab, box 2.

REPORT 102: MEDICAID CONTRACT

102.1 Introduction

- A) The purpose of the Medicaid Contract Report is to submit information annually on:
1. Expenditures of payments for the MQD contracted services;
 2. Employment information;
 3. On-going state or federal sanction proceedings, prohibitions, restrictions, on-going civil or criminal investigations, and descriptions of past sanctions or resolved civil or criminal cases, within the past five years and related to the provision of Medicare or Medicaid services by the contracting entity;
 4. Contributions to the community; and
 5. Management and administrative service contracts for Med-QUEST services made in Hawaii (State) and outside of the State.

102.2 Applicable Contract Sections

- A) Section 6.2.F.4.a (Report Descriptions) describes the requirements of the Medicaid Contract Report in compliance with HRS §103F-107.

102.3 Terms and Definitions

- A) **Additional Compensation:** Other than annual salary, includes bonus, stock awards, option/SAR awards, and any other additional compensation to include additional benefits provided to an employee (e.g., additional health benefits, automobiles, etc.).
- B) **State and Federal Sanctions:** Includes any on-going state or federal sanction proceedings, prohibitions, restrictions, on-going civil or criminal investigations, related to the provision of Medicare or Medicaid services by the contracting entity, to the extent allowed by law.
- C) **Adverse Action:** Includes any final adverse outcome or final adverse judgement (e.g., penalty, sanction, fine, suspension) as a result of the legal case.

- D) **Contributions to the Community:** Includes monetary and non- monetary contributions to Hawaii community development projects and health enhancements, provided that contracted services shall not be included.
- E) **Management and Administrative Service Contracts:** Includes any management or administrative service contracts for Med- QUEST services made in Hawaii and outside of the State. These types of contracts include, but are not limited to, pharmacy benefit management, transportation, case management, behavioral health, auditing, mailing of benefit packages, after-hour call numbers, hearing, and vision.

102.4 Methodology

- A) The Health Plan shall collect and maintain records of all data required for this report.

B) The Health Plan shall complete the embedded “MCR_Report Template” within the report. The excel document contains five distinct tabs for subject-specific reporting.

1. Financial Expenditures

- a. The Health Plan shall enter the reporting period in cell B3 as the State Fiscal Year (SFYxx).
- b. The Health Plan shall report the total dollars received by DHS for contracted services (Total Award), and shall report in United States dollars, the enumerated expenditures and other use of the Health Plan’s Total Award. The worksheet will automatically calculate the percent of Total Award for each category, as well as the total of expenditures reported. The Health Plan shall enter the total gain or loss in cell B23.
- c. If the Health Plan has any additional information to report, such information shall be entered into the “Health Plan Notes” box provided.

2. Employment Information

- a. The Health Plan shall enter the reporting period in cell B3 as the State Fiscal Year (SFYxx).

- b. In the first table, the Health Plan shall enter the total number of full-time equivalents (both in-State and out-of-State) hired for the contracted services, in cell C5. Additionally, starting from cells B8 and C8, the Health Plan shall enter and list the total number of employees located in the State by category of work performed.
- c. If the Health Plan has any additional information to report, such information shall be entered into the "Health Plan Notes" box provided.
- d. In the second and third tables, the Health Plan shall enter the information on its five highest paid employees in Hawaii and nationwide (if applicable) during the reporting period. The Health Plan shall include the employee's name, title, description of position, and total compensation. Total compensation shall be further broken down into annual salary and additional compensation.
- e. If the Health Plan has any additional information to report, such information shall be entered into the "Health Plan Notes" box provided.

3. State and Federal Sanctions

- a. The Health Plan shall enter the reporting period in cell C3 as the State Fiscal Year (SFYxx).
- b. The Health Plan shall provide descriptions of any ongoing state or federal sanction proceedings, prohibitions, restrictions, ongoing civil or criminal investigations, and descriptions of past sanctions or resolved civil or criminal cases, within the past five years and related to the provision of Medicare or Medicaid services by the contracting entity, to the extent allowed by law. The Health Plan shall report: the case name; the file number; whether the case/sanction is state, federal, or both; the court; a description of the case; any Adverse Action; and the current status.
- c. If the Health Plan has any additional information to report, such information shall be entered into the "Health Plan Notes" box provided.

4. Contributions to the Community

- a. The Health Plan shall enter the reporting period in cell B3 as the State Fiscal Year (SFYxx).
- b. The Health Plan shall report: the recipient of the contribution and the total amount of the contribution in United States dollars.
- c. The worksheet will automatically calculate the total dollars contributed to the community during the reporting period.
- d. If the Health Plan has any additional information to report, such information shall be entered into the "Health Plan Notes" box provided.

5. Management and Administrative Contracts

- a. The Health Plan shall enter the reporting period in cell B3 as the State Fiscal Year (SFYxx).
- b. The Health Plan shall report the contractor name, description of services provided, total cost, and primary category for this contract.
- c. The worksheet will automatically calculate the total dollars spent during the reporting period on management and administrative contracts.
- d. If the Health Plan has any additional information to report, such information shall be entered into the "Health Plan Notes" box provided.

102.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

- 1. For each position having an FTE requirement, the health plan must staff at least that many FTEs.
- 2. Total number of federal and state Adverse Actions within the past five years.

REPORT 103: OVERPAYMENTS

103.1 Introduction

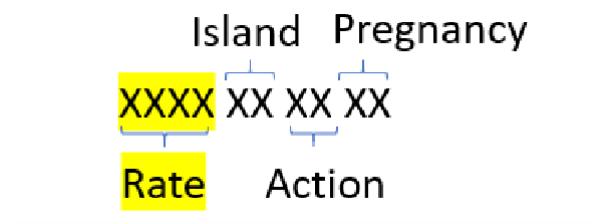
- A) The Health Plan shall report to DHS all overpayments identified during the reporting period, whether it is an overpayment to the Health Plan by DHS or an overpayment to a provider by the Health Plan.
- B) DHS shall use the information submitted in the Health Plan Overpayments Report to populate the quarterly CMS-64 and to calculate the next year's capitation rates.

103.2 Applicable Contract Sections

- A) Section 6.2.F (Report Descriptions) describes the reporting requirements of the Health Plan Overpayments Report.
- B) Section 12.1 (Fraud, Waste and Abuse (FWA)) describes the requirements for the Health Plan to promptly report identified overpayments to the State and how the overpayments can be recovered.

103.3 Terms and Definitions

- A) **Overpayment:** For the purposes of this report, overpayment means either:
 - 1. For Overpayments made to the Health Plan, the amount paid by DHS to the Health Plan which is in excess of the capitation owned to the Health Plan due to reasons including, but not limited to, assignment of incorrect capitation rate code, member duplication, or member deceased.
 - 2. For Overpayments made to providers, per 42 CFR § 438.2, any payment made to a network provider by a Health Plan to which the network provider is not entitled to under Title XIX of the Act or any payment to a Health Plan by a State to which the Health Plan is not entitled to under Title XIX of the Act.
- B) **Rate Code:** The Capitation Rate Code Med-QUEST pays for a member as reported on the daily 834 Enrollment File. This code is listed in Loop 2000, Segment ID REF, Element ID REF, as the first 4 digits. See the graphic below for clarification.



C) Category of Service:

1. **Facility Inpatient:** services recorded on Bill Type 11X, 12X, 18X, 21X, 28X, 41X, or 86X
2. **Facility Outpatient:** services recorded on Bill Type 13X, 14X, 32X, 33X, 34X, 43X, 61X, 63X, 71X, 72X, 73X, 74X, 75X, 76X, 77X, 79X, 81X, 82X, 83X, 84X, 85X, or 89X
3. **Professional:** services recorded on a CMS 1500 claim that do not have an HCBS procedure code
4. **Home and Community Based Services (HCBS):** services recorded on a CMS 1500 with the procedure codes H0045, S5101, S5102, S5105, S5108, S5109, S5110, S5111, S5115, S5116, S5120, S5121, S5125, S5130, S5135, S5140, S5150, S5151, S5160, S5161, S5162, S5165, S5170, S5185, S9122, S9123, S9124, S9125, S9452, T1005, T1019, T2001, T2003, T2004, T2022, T2025, T2028, T2029, T2031, T2033, T2035, T2038, or T2039
5. **Pharmacy:** services recorded on an NCPDP
6. **Nursing Home/Waitlist:** services recorded on Bill Type 22X, 23X, 65X, or 66X

103.4 Methodology

A) This report is organized into four sections:

- B) In **Section 1: 60 Day Notification of DHS Overpayments to Health Plans**, the Health Plan shall provide a list of any instances of excess capitation DHS paid to the Health Plan identified within the past 60 days. The Health Plan may also report any instances of potential underpayment in capitation in this Section. Where the Cause of Excess Capitation is identified as "Member Duplicated", the Health Plan shall provide each member record

on the 834 enrollment file identifying that member. The Health Plan shall refer to OPR_MLDF_DataFormat for additional information on the fields reported in Section 1.

1. The 60-day reporting requirement will remain in effect; however, if the 60-day reporting deadline aligns with a scheduled monthly submission, the payment can be included in that monthly report.
2. If the 60-day deadline falls outside of a scheduled monthly reporting period, the information may be submitted to MQD on an ad hoc basis to ensure timely reporting compliance.

C) In **Section 2: Health Plan Overpayments to Providers Identified during Report Period (monthly)**, the Health Plan shall provide an itemized list of all encounters identified as overpayments during the reporting period or encounters identified as overpayments in previous reporting periods where recoveries are still being made. The Health Plan shall refer to OPR_Monthly_Report_Template for additional information on the fields reported in Section 2.

1. It is understood that the Health Plan may not be able to complete recovery of overpayment until after the reporting period. In this situation, the Health Plan will include the encounter identified as an overpayment on each instance of the Overpayments Report until the Recovery Status is complete. The Health Plan shall report to DHS the full overpayment identified, regardless of whether the Health Plan negotiates and retains a lesser repayment amount with the provider.
2. The Date of Discovery should be on or before the date any revised encounter was submitted.

D) In **Section 3: Health Plan Overpayments Review Process (quarterly)**, the Health Plan will provide a description of the work they do to review claims to identify instances of Overpayments. The Health Plan shall provide an overview of the proportion of claims identified as overpayments during the reporting period. The Health Plan shall also attest to having contractually required processes in place should a provider identify any overpayments paid by the Health Plan to the provider.

E) In **Section 4: Health Plan Overpayments to Providers Identified during Reporting Period (annual)** in accordance with 42 CFR

438.608(d)(3), each Health Plan must submit an annual report to MQD identifying all provider overpayments that were identified and/or recovered during the annual reporting period. The Health Plan shall refer to OPR_Annual_Report_Template for additional information on the fields reported in Section 4.

103.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. Percent of claims identified as Health Plan Overpayments to Providers that were resubmitted to HPMMIS
2. Percent of claims identified as Health Plan Overpayments to Providers with a Date of Discovery within 120 days of Date of Service
3. Did the Health Plan provide a description of the steps taken to review the 834 enrollment file this reporting period?
4. Percent of Total Overpayments that have been Recovered
5. Percent of encounters adjusted and re-submitted to HPMMIS within 200 days of adjudication or adjustment of the claim.

REPORT 104: ENCOUNTER DATA/FINANCIAL SUMMARY RECONCILIATION

104.1 Introduction

- A) The purpose of this report is to monitor the accuracy and completeness of data in the Hawaii Prepaid Medical Management Information System (HPMMIS) by reconciling it against each Health Plan's financial ledgers. The goal of reconciliation is to ensure that data in HPMMIS is actuarially sound for the purpose of capitation rate-setting. Data in HPMMIS will be reconciled against the Health Plans' financial ledgers in two ways:
1. Amount of money Health Plans recorded spending on claims
 2. Number of CRNs

104.2 Applicable Contract Sections

- A) Section 6.2.F (Report Descriptions) contains the description of the Encounter Data/Financial Summary Reconciliation Report.
- B) Section 6.4.A (Encounter Data Reporting) describes the process DHS and the Health Plans shall use to reconcile data.

104.3 Terms and Definitions

- A) **Reject Code & Reason:** According to the 824 and 999 files MQD generates for each Health Plan every encounter processing cycle, the rejection code and reason associated with that encounter.
- B) **Pended Code & Reason:** According to the 241 file MQD generates for each Health Plan every encounter processing cycle, the pend code and reason associated with that encounter.
- C) **Denial Code & Reason:** According to the reports delivered to Health Plans each processing cycle, the denial code and reason associated with that encounter.
- D) **Valid Claim:** A valid claim is a claim submitted for a given service rendered to an active member of the Health Plan by an active provider.
- E) **Final Adjudicated Claims:** Reconciliation will be conducted on paid claims in their final adjudication status as of the date MQD extracts data from

HPMMIS.

104.4 Methodology

A) At the beginning of each Reconciliation Interval, DHS shall specify the start and end dates of the reconciliation period for the Health Plan. The reconciliation process will occur on an adjudicated basis for claims paid or adjusted during the reconciliation period. Health Plans shall use the Managed Care Encounter Reconciliation (MCER) files extracted from HPMMIS, applying a two-month lag to ensure that all encounters have reached their most recent adjudication status. For example, a reconciliation period covering the first quarter would use MCER files extracted two months later, such as the May files for the Q1 reconciliation. These extracts contain all encounters, in their most recent adjudication status, for each Health Plan, with adjudication dates falling within the reconciliation period. The data pull date refers to the date on which the MCER files are uploaded to the DHS SFTP site. Memorandums QI-2516A/CCS-2503A specify the field formats and definitions required by DHS and Health Plans for reconciliation.

1. Health Plans shall extract institutional encounters at the header level; professional and pharmacy encounters shall be extracted at the line level.
2. Health Plans shall extract only two adjudicated-approved MCER files (Adjudication Status 31) from HPMMIS: one for ABD encounters and one for non-ABD encounters, for a single quarter of data, based on the Health Plan Paid Date (field name: HP Paid Date). For example, the AlohaCare files would be:
 - a. ENC_XALOHA_ADJ.TXT
 - b. ENC_ALOHAC_ADJ.TXT
3. Health Plans shall combine each Health Plan's ABD and non-ABD encounters into a single extract. For example, AlohaCare's extract will contain all encounters where the Health Plans ID is "ALOHAC" as well as "XALOHA". They shall then complete Line Item B (MQD extract) in the "Summary" tab of the Reconciliation spreadsheet (EDFS_ALDF_MLDF_Rel07.24.XLSX file). Line Item B summarizes: 1) the total paid amount for all CRNs, and 2) the total number of CRNs, broken out into a "Total" column and the following six categories of service:

- a. Facility Inpatient
 - 1) DRG Ineligible
 - 2) DRG Eligible
 - b. Facility Outpatient
 - c. Professional/Other
 - d. Pharmacy
 - e. Nursing Home and Waitlist
 - f. Home and Community Based Services (HCBS)
4. Health Plans shall extract data based on the paid claims submitted to DHS as of the date DHS extracted data from HPMMIS and shall complete Line Item A (MCO data) in the "Summary" tab of the Reconciliation spreadsheet.
5. Health Plans shall also complete the breakdown items on the "Summary" tab. These breakdown items summarize the Total Paid Amount and Total Number of CRNs (Line Items shown in parentheses), where:
- a. HPMMIS and the Health Plan data match (D).
 - b. HPMMIS and the Health Plan data don't match (E).
 - 1) This amount should represent the net difference in Paid Amounts that do not match. If an encounter in the Health Plan's data has a higher Paid Amount than the encounter in HPMMIS, this would be a positive value; conversely, if an encounter in the Health Plan's data has a lower Paid Amount than the encounter in HPMMIS, this would be a negative value. The total amount represented in Line Item E will sum all these values for a net total.
 - c. HPMMIS has data the Health Plan does not (F).
 - d. The Health Plan has data, but it is not reflected in HPMMIS's data because it was pended by MQD with Adjudication Status 11 (G1).
 - e. The Health Plan has data, but it is not reflected in HPMMIS's data because it was denied by MQD with Adjudication Status 41 (G2).

- f. The Health Plan has data, but it is not reflected in HPMMIS's data because it was rejected by MQD (G3).
 - g. The Health Plan has data, but it is not reflected in HPMMIS's data because the Health Plan did not submit it (G4).
 - h. The Health Plan has data, but it is not reflected in HPMMIS's data where the Health Plan believes DHS accepted the data but it is not present for an unknown reason (G5).
6. In the Reconciliation spreadsheet, Health Plans shall provide extracts of the data defined in Line Items D, E, F, G1, G2, G3, G4, and G5 in the remaining tabs. Each tab between D and G5 will request the following information for each claim:
- a. Form Type
 - b. Category (Facility Inpatient, Facility Outpatient, Professional/Other, Pharmacy, Nursing Home and Waitlist, or Home and Community Based Services)
 - c. MQD CRN (from the DHS extract, if applicable)
 - d. HP Claim Number (from the Health Plan data, if applicable)
 - e. Service Begin Date (from the DHS extract, if applicable)
 - f. Adjudication Status (from the DHS extract, if applicable)
 - g. Adjudication Status (from the Health Plan extract, if applicable)
 - h. HP Paid Amount (from the DHS extract, if applicable)
 - i. MCO Paid Amount (from the Health Plan extract, if applicable)
 - j. Rejection/Denied/Pended Code (if applicable)
 - k. Rejection/Denied/Pended Reason (if applicable)
 - l. Reason not submitted (if applicable)

B) In **Section I of the EDFS Report Template**, Health Plans shall provide additional information on the ledger paid amounts during the reconciliation period, as well as the amounts included in the reconciliation process.

1. Report the Health Plan's total ledger paid amount for benefit expenses

during the reconciliation period (Question 5). This should include all services paid by the Health Plan on behalf of members and should align with the data Health Plans report on the annual QI Data Request to the MQD actuaries.

2. Report the Health Plan's ledger paid amount that was included in the reconciliation process completed (Question 6). This amount should align with what was reported in Line Item A of the Summary tab in the Reconciliation spreadsheet.
3. By service types (determined by the Health Plan), identify any services paid during the reconciliation period and included in the Health Plan's total ledger paid amount that were not included in the reconciliation process completed in **Section I**, either completely or partially (Question 7). Here, the Health Plan shall parse the total dollar value reported in the previous metric by type of service. As an example, if the Health Plan spent \$1000 on all transportation costs, but only \$600 of these costs were included in the encounter data reconciliation process, the Health Plan must list the total ledger paid amounts for these services (\$1000) in the second column, and list what was included in the reconciliation process (\$600) in the third column. The sum of values in the "Total Ledger Paid Amount" in Question 7 must add up to the difference between the values reported in Questions 5 and 6. If 100% of the ledger paid amount for a given service during the reporting period was included in the Encounter Data Reconciliation, those services do not need to be included in the response to Question 7.

C) In **Section II of the EDFS Report Template**, Health Plans shall submit a variety of metrics tied to encounter data completeness and timeliness during the reporting period.

1. The Health Plans shall report the number of claims adjudicated during the reporting period, and of those, how many of these were submitted as encounters to DHS, in the following categories:
 - a. Adjudicated valid claims that the Health Plan denied
 - b. Adjudicated valid claims that the Health Plan adjusted
 - c. Adjudicated valid claims that the Health Plan identified as Overpayments that the Health Plan did not adjust

- d. Adjudicated valid claims where the Health Plan determined that no Medicaid liability exists/no Medicaid payment shall be made
 - e. Adjudicated valid claims for Health Plan value-added services
 - f. Total de-duplicated count of claims included in above categories
- 2. The Health Plans shall report on Plan Staff Services (see memorandum QI-2505/CCS-2501) provided directly to members by Health Plan employees or by the Health Plan's contractors who perform services on behalf of the Health Plan using its system, functioning as an extension of staff. The Health Plan shall group these services into ten categories (Assessments; Care Facilitation; Care Planning; Care Transitions; Disease Prevention and Management & Education; Emergency and Disaster Support; Health-Related Social Needs; In-Home and Community Services; Outreach; and Referrals and Care Management) and report the number of services provided, the costs of those services, the total claims paid amount, and how many of these services were captured as claims and submitted as encounters to DHS.
- 3. The Health Plans shall report the number and paid amounts for adjudicated claims, as well as the number and paid amounts for encounters, by the categories of service defined in this report during the reporting period, and shall identify how many of these were submitted to DHS.
- 4. The Health Plans shall report on claims and encounters with service dates older than 15 months prior to the first date of the reporting period. The Health Plans shall categorize these claims according to the categories of service defined in this report and identify how many were adjudicated and, of those adjudicated, how many were submitted as encounters.
 - a. If the Health Plan has not submitted all adjudicated claims with service dates older than 15 months prior to the first date of the reporting period as encounters, the Health Plan shall list the reasons in the open text box following the table.

104.5 Key Performance Indicators (KPIs)

- A) DHS shall use the following KPIs to evaluate Health Plan performance. The calculations of the variances, or percent changes, are provided in the "Summary" tab (rows 30 and 31) of the Reconciliation spreadsheet. The

percentages are calculated based on the numbers the Health Plans provide in the EDFS Report template.

1. Variance between Health Plan and Encounter Data – Total (Amount \$)
2. Variance between Health Plan and Encounter Data – Facility Inpatient DRG Ineligible (Amount \$)
3. Variance between Health Plan and Encounter Data – Facility Inpatient DRG Eligible (Amount \$)
4. Variance between Health Plan and Encounter Data – Facility Outpatient (Amount \$)
5. Variance between Health Plan and Encounter Data – Professional/Other (Amount \$)
6. Variance between Health Plan and Encounter Data – Pharmacy (Amount \$)
7. Variance between Health Plan and Encounter Data – Nursing Home/Waitlist (Amount \$)
8. Variance between Health Plan and Encounter Data – Home and Community Based Services (Amount \$)
9. Variance between Health Plan and Encounter Data – Total (# of CRNs)
10. Variance between Health Plan and Encounter Data – Facility Inpatient DRG Ineligible (# of CRNs)
11. Variance between Health Plan and Encounter Data – Facility Inpatient DRG Eligible (# of CRNs)
12. Variance between Health Plan and Encounter Data – Facility Outpatient (# of CRNs)
13. Variance between Health Plan and Encounter Data – Professional/Other (# of CRNs)
14. Variance between Health Plan and Encounter Data – Pharmacy (# of CRNs)
15. Variance between Health Plan and Encounter Data – Nursing Home/Waitlist (# of CRNs)

16. Variance between Health Plan and Encounter Data – Home and Community Based Services (# of CRNs)
17. Percent of the total ledger paid amount used in the reconciliation process
18. Percent of the total ledger paid amount not submitted as encounters during the reporting period
19. Percent of services rendered by Health Plan personnel that were submitted as encounters
20. Percent of encounters submitted by the Health Plan of all claims adjudicated during the reporting period
21. Percent of claims with service dates older than 15 months that have been adjudicated
22. Percent of claims with service dates older than 15 months that have been submitted as encounters

104.6 Special Submission Instructions

- A) Health Plans shall provide the completed Reconciliation spreadsheet as an Excel (.xlsx) file, including the “Summary” tab and the supporting extracts for tabs D through G5.
- B) Health Plans shall attach the completed Reconciliation spreadsheet to the completed EDFS Report template (.docx file) and upload the Word file to the Health Plans’ SharePoint sites and to the DHS’s SFTP site.

REPORT 105: MEDICAL LOSS RATIO

105.1 Introduction

- A) The purpose of the Medical Loss Ratio (MLR) Report is to calculate the amount of premium dollars the Health Plan spends on medical care.

105.2 Applicable Contract Sections

- A) Section 6.2.F.1.a (Report Descriptions) describes the requirements of the MLR Report in compliance with 42 CFR §438.74, §438.8, and §438.604.

105.3 Terms and Definitions

A) 438.3(e)(2) Incurred Claims

1. 438.8(e)(2)(i) Incurred Claims: Incurred claims must include:

- a. Line A: Direct claims paid to providers for services or supplies covered under the contract and services meeting the requirements of §438.3(e) provided to enrollees. Incurred claims should reflect total paid and incurred claims with claims run-out through six (6) months after the end of the reporting period.
 - 1) Line A.1: Report separately sub-capitation paid to contracted network providers attributed to services provided.
 - 2) Line A includes Claims expenditures meeting requirements of §438.3(e) include non-state plan services that the Health Plan voluntarily provides through the QUEST
 - 3) The Health Plan shall consult with CMS Information Bulletin (May 15, 2019) on MLR requirements related to Third Party Vendors for requirements on treating payments made by the Health Plan to sub-contracted third-party vendors.
 - i In general, a Health Plan may only include in incurred claims for Medicaid covered services amounts that the subcontractor actually pays the medical provider or supplier for providing Medicaid covered services to enrollees. Where the subcontractor is performing an administrative function such as eligibility and coverage

verification, claims processing, utilization review, or network development, expenditures and profits on these functions would be considered a non-claims administrative expense as described in 42 CFR 438.8(e)(2)(v)(A), and should not be counted as an incurred claim for the purposes of MLR calculations.

- ii An exception to the general approach applies when a subcontractor, through its own employees, provides Medicaid covered services directly to enrollees. In this circumstance, the entire portion of the amount the Health Plan pays to the third-party vendor that is attributable to the third-party vendor's direct provision of Medicaid covered services should be included in incurred claims, even if such amount includes reimbursement for the third party vendor's own administrative costs related to the direct provision of Medicaid covered services.

b. Line B: Unpaid claims liabilities. Unpaid claims reserves reflect the estimated outstanding liabilities for all medical and prescription drug health care services. This includes items such as incurred but not yet reported (IBNR) claims, claims in course of settlement (ICOS), and claims that are adjudicated but not yet paid.

- 1) Line B.1: The Health Plan shall report separately reserve for incentive pool, withhold adjustments, and bonus amounts payable to providers.

c. Line C: Withholds from payments made to network providers.

d. Line D: Claims that are recoverable for anticipated coordination of benefits (or third party liability), i.e., recoveries received as a result of determining that another insurance plan has primary payment responsibility.

e. Line E. Claims payments recoveries received as a result of subrogation, i.e., recoveries received as a result of determining that another party is responsible for the medical expense.

f. Line F: Incurred but not reported (IBNR) claims based on past

experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.

g. Line G: Changes in other claims-related reserves.

h. Line H: Reserves for contingent benefits and the medical claim portion of lawsuits.

2. 438.8(e)(2)(ii): Amounts that must be deducted from incurred claims include the following:

a. Line A: Overpayment recoveries received as a result of overpayment to a network providers (entered as a positive value in the template).

b. Line B: Prescription drug rebates received and accrued (enter as a positive value in the template).

3. 438.8(e)(2)(iii): Expenditures that must be included in incurred claims include the following:

a. Line A: The amount of incentive and bonus payments made or expected to be made to network providers. This includes payments made to a physician, or physician group, beyond any salary, fee-for-service payments, capitation, or withhold amount. This should include the pay for performance pools payments made to hospitals.

b. Line B: The amount of claims payments recovered through fraud reduction efforts.

1) Line B.1: Report separately the amount of fraud reduction expense directly related to fraud recovery activities. As specified in § 438.8(e)(4), this amount must not include expenditures on activities related to fraud prevention as adopted for the private market in 45 CFR part 158, Commercial Issuer Use of Premium Revenue: Reporting and Rebate Requirements.

2) Line B.2: Report separately total fraud recoveries (entered as a positive value in the template). Fraud recoveries up to the total fraud recoveries expense reported above are excluded from the incurred claims calculation.

4. 438.8(e)(2)(iv): Amounts that must either be included in or deducted from incurred claims:

- a. Line A: Payments made to DHS for DHS mandated solvency funds (entered as a positive value in the template). Please note, Hawaii does not have mandated solvency funds; these lines should remain blank in the template.
- b. Line B: Receipts from DHS for DHS mandated solvency funds (entered as a positive value in the template). Please note, Hawaii does not have mandated solvency funds; these lines should remain blank in the template.

5. 438.8(e)(2)(v): Amounts that must be excluded from incurred claims:

- a. Line A: Non-claims costs as defined in § 438.8(b). Report separately for the following if they have been reported on line **438.8(e)(2)(i)(A) or other lines above and indicate which lines contain these amounts in the Expense Allocation Narrative column:**
 - 1) Line A.1: Amounts paid to third party vendors for secondary network savings.
 - 2) Line A.2: Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.
 - 3) Line A.3: Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.
 - 4) Line A.4: Fines and penalties assessed by regulatory authorities based on an examination or audit.
- b. Line B: Amounts paid to DHS as remittance under § 438.8(j). This is the amount paid, if any, as a result of the Medicaid minimum MLR requirement for the prior contract year.
- c. Line C: Amounts paid to network providers under § 438.6(d). The

facility enhancement pass-through payments made for HHSC LTC & private nursing homes and HHSC acute and private hospital access payments. This amount is expended to be exactly equal to the facility enhancement pass-through premium revenue as displayed in the premium revenue section.

- d. Line D: Reinsurance recoveries related to State mandated reinsurance contracts. Reinsurance premiums and recoveries are excluded from the MLR calculation with the exception of state-mandated reinsurance contract requirements (entered as a positive value in the template). Please note, Hawaii does not require Health Plan reinsurance coverage; these lines should remain blank in the template.

B) 438.8(e)(3) Activities that improve health care quality.

1. 438.8(e)(3)(i): Activities that meet the requirements of 45 CFR 158.150(b) and are not excluded under 45 CFR 158.150(c):

Consistent with NAIC guidelines for the Supplemental Health Care Exhibit Part 3, Quality Improvement Expenses are defined as expenses that control or contain cost with the primary purpose of improving health care quality. These expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. These expenses can be objectively measured, and must not be billed or allocated as clinical or claims costs.

- a. Line A: Expenses for activities to improve health outcomes. These are expenses for direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g. face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes.
- b. Line B: Expenses for activities to prevent hospital readmission.
- c. Line C: Expenses for activities to improve patient safety and reduce medical errors.

- d. Line D: Expenses for wellness and health promotion activities.
These include expenses for programs that provide wellness and health promotion activity (e.g., face-to-face, telephonic, web-based interactions or other means of communication).

2. 438.8(e)(3)(ii): Activities related to external quality review

(EQR): Expenses for mandatory and optional EQR- related activities as defined in 42 CFR 438.358.

3. 438.8(e)(3)(iii): Expenditures related to health information

technology and meaningful use: This includes Health Information Technology expenses required to accomplish the activities designed for use by the Health Plan, health care providers or enrollees for the electronic creation, maintenance, access, or exchange of health information, consistent with Medicare/Medicaid meaningful use requirements.

- a. The Health Plan shall exclude costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in Health Information Technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims.

4. Expenditures and activities that must NOT be included in quality improving activities are:

- a. Those that are designed primarily to control or contain costs;
- b. The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;
- c. Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from Total Medical Related Revenues;
- d. Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;
- e. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment

capabilities or to meet regulatory requirements for processing claims, including maintenance of current code sets;

- f. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
- g. All retrospective and concurrent utilization review;
- h. The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
- i. Provider credentialing;
- j. Marketing expenses; and
- k. Costs associated with calculating and administering individual Member incentives.

C) 438.8(f)(2) Premium Revenue

- 1. 438.8(f)(2)(i): State capitation payments for all enrollees under a risk contract, excluding payments made under § 438.6(d):** Risk-adjusted capitation payment revenue for the Quest Integration program for the contract period. The total amount on this line should not include facility enhancement pass-through revenue, as that is reported on the line below. The member share of cost capitation deductions should be added back to premium revenue.
 - a. Line A: On the separate line provided, report facility enhancement pass-through revenue. This amount is expected to be exactly equal to the pass-through claims expense as reported in the incurred claims section.
- 2. 438.8(f)(2)(ii): State-developed one time payments, for specific life events of enrollees:** For example, delivery kick- payment. Please note, Hawaii does not have such one-time payments; these lines should remain blank in the template.
- 3. 438.8(f)(2)(iii): Withhold payments approved under § 438.6(b)(3):**

- a. Line A: Total Health Plan withhold of capitation revenue. This is the total revenue withheld. Capitation payment revenue in line 438.8(f)(2)(i) should be net of this withhold amount.
- b. Line B: Health Plan withhold earned back. The amount of the quality withhold earned back based on quality metrics established by MQD for the contract period. For withholds that have not yet been measured and reported by MQD, The Health Plan should provide an estimated quality withhold payout.

4. 438.8(f)(2)(iv): Total amount of co-pays waived by the Health Plan from provider's collection responsibility: The amount of unpaid member cost-sharing dollars where an Health Plan intentionally waived the provider's responsibility to collect the member pay.

5. 438.8(f)(2)(v): Changes to unearned premium reserves: Change in the premium reserve for the portion of Medicaid insurance coverage that has not yet expired.

6. 438.8(f)(2)(vi): Net payments or receipts related to risk sharing mechanisms developed in accordance with § 438.5 or § 438.6:

- a. Line A: Aggregate gain and loss share settlements. Total amount of Health Plan payment made to DHS (Line A.1) or recoupment from DHS (Line A.2) related to the aggregate gain and loss share agreement (entered as a positive value on both lines in the template).
- b. Line B: Retroactive enrollment settlement corridor. Total Health Plan settlement related to the retroactive enrollment risk corridor arrangement (entered as a positive value on both lines in the template); payments made to DHS must be listed in line B.1 and recoupments from DHS must be listed in line B.2.
- c. Line C. High-cost drugs risk corridor settlements. Total Health Plan settlement related to the high-cost drug risk corridor arrangement (entered as a positive value on both lines of the template). Payments made to DHS must be listed in line C.1 and recoupments from DHS must be listed in line C.2.
- d. Line D. High risk newborn pool settlements: Total Health Plan

settlement related to the high risk newborn pool arrangement (entered as a positive value on both lines of the template). payments made to DHS must be listed in line D.1 and recoupments from DHS must be listed in line D.2.

D) 438.8(f)(3) Federal, State, and local taxes and licensing and regulatory fees. Consistent with NAIC guidelines for completion of the Supplemental Health Care Exhibit Part 1, taxes and fees pertain to amounts a governmental or regulatory body charges the Health Plan to perform a service which is allocated to Medicaid business in Hawaii. Additionally, all Federal and State taxes and assessments and licensing or regulatory fees should be reported in accordance with the provisions in §§ 422.2420(c)(2) and 423.2420(c)(2) of the Medicare Advantage MLR regulations. Taxes, licensing and regulatory fees for the MLR reporting year include the categories below.

1. 438.8(f)(3)(i): Statutory assessments to defray the operating expenses of any State or Federal department

2. 438.8(f)(3)(ii), 438.8(f)(3)(iv): Examination fees, state premium taxes, local taxes and assessments. These include the following:

- a. Examination fees in lieu of premium taxes as specified by Hawaii State law;
- b. Guaranty fund assessments;
- c. Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to DHS directly;
- d. Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by Hawaii;
- e. Advertising required by law, regulation or ruling, except advertising associated with investments;
- f. State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments; and

- g. State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.
- h. In lieu of reporting state premium taxes, the Health Plan may choose to report payment for community benefit expenditures, on line 438.8(f)(3)(v), limited to the highest premium tax rate for Hawaii, but the Health Plan may not report both.

3. 438.8(f)(3)(iii): Federal taxes and assessments:

- a. The Health Plan shall include all federal taxes and assessments allocated to health insurance coverage reported under Section 2718 of the Federal Public Health Service Act
- b. The Health Plan shall exclude:
 - 1) Federal income taxes on investment income and capital gains; and
 - 2) The Health Insurer Fee

4. 438.8(f)(3)(v): Payments for community benefit expenditures as defined in 45 CFR 158.162(c) that are otherwise exempt from Federal income tax: Expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health, and relief of government burden, as defined in the NAIC supplemental health care exhibit.

- a. Line A: Input the highest premium tax rate in Hawaii
- b. Line B: Using the Yes/No toggle, indicate if the Health Plan is exempt from federal income taxes

E) 438.8(h) Credibility Adjustment: As published by CMS in the Information Bulletin MLR Credibility Adjustments, the credibility adjustment is used to account for random statistical variation related to the number of enrollees in a Health Plan. Credibility adjustment categorizes the Health Plan into one of three groups:

- 1. Fully-credible:** Health Plans with sufficient claims experience (as measured by member months) are assumed to experience MLRs that are

not subject to random variation as observed in statistically insignificant samples. Such Health Plans will not receive a credibility adjustment of their MLR.

2. **Partially-credible:** Health Plans with sufficient claims experienced (as measured by member months) to calculate an MLR with a reasonable chance that the difference between the actual and target medical loss ratios is statistically significant. Such Health Plans will receive a partial credibility adjustment to their calculated MLRs.
3. **Non-credible:** Health Plans with insufficient claims experience, measured in terms of member months, to calculate a reliable MLR. Such plans will not be measured against the MLR standard; Health Plans in this group are presumed to meet or exceed the target MLR standard.
4. The following table illustrates the Medicaid and CHIP credibility adjustment factors utilized in the MLR formula:

MLR Credibility Adjustment Table for Medicaid and CHIP Health Plans	
Standard Plans Member Months in MLR Reporting Year	Standard Plans Credibility Adjustment
< 5,400	Non-credible
5,400	8.4%
12,000	5.7%
24,000	4.0%
48,000	2.9%
96,000	2.0%
192,000	1.5%
380,000	1.0%
> 380,000	Fully Credible

- F) **Medical Loss Ratio Standard:** Minimum MLR percentage that is at least as high as the CMS guidelines of 85%.
- G) **Medical Loss Ratio (MLR):** The sum of lines in 438.3(e)(2) Incurred Claims and 438.8(e)(3) Quality Improvement Expenses divided by the difference of lines in 438.8(f)(2) Premium Revenue and 438.8(f)(3) Taxes and Fees, e.g. (Incurred Claims + Quality Improvement)/(Premiums – Taxes and Fees).
- H) **Adjusted Medical Loss Ratio:** The value of the Medical Loss Ratio plus the

Credibility Adjustment, as defined above.

- I) **Remittance Amount Due to DHS:** The product of the Medical Loss Ratio Standard minus the Adjusted Medical Loss Ratio and the Premium Revenue minus Taxes and Fees, e.g. $(85\% - \text{Adjusted MLR}) \times (\text{Premium Revenue} - \text{Taxes and Fees})$. Any positive values indicate that the Health Plan owes a remittance to DHS.

105.4 Methodology

A) The report is organized into one section.

1. Expense Allocation Narratives shall be provided as appropriate;
2. The Summary Calculation tab shall auto-populate to calculate the Health Plan's MLR.

B) The Health Plans shall allow for six months of run-out after the end of the reporting period.

C) The Health Plan shall begin by populating the Data Collection tab which is separated into the five major elements of the calculation: Incurred Claims, Quality Improvement Expenses, Premium Revenue, Taxes and Fees, and a Credibility Adjustment.

D) The Health Plan shall use the designated column on the Data Collection tab to provide their Expense Allocation Narrative. The Health Plan is required to provide their Expense Allocation Narrative to demonstrate how the methods used in expense allocation meet the requirements in accordance with § 438.8(g).

E) The Expense Allocation Narrative generally requires that:

1. Each expense is included in only one type of expense, unless a portion of that expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense. In this case, the expense must be pro-rated between types of expenses.
2. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.
3. Allocation to each category must be based on a generally accepted

accounting method that is expected to yield the most accurate results.

4. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
5. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities.

F) Following the completion of the Data Collection template and Expense Allocation Narrative, the Health Plan shall receive a Summary Calculation of their Medical Loss Ratio on the second tab of the workbook

105.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. Meets MLR Standard: The MLR Report uses the lines reported in the Data Collection template to calculate if the Health Plan meets the MLR Standard.

105.6 Special DHS Review

- A) Should the Health Plan's Medical Loss Ratio be lower than 85%, DHS and DHS-contracted staff will calculate a Remittance Amount for the Health Plan, as defined in the Terms and Definitions.
- B) In situations where the Health Plan is non-credible based on reported member months, it is assumed that the Health Plan meets the minimum MLR Standard.
- C) For situations where the Health Plan is partially-credible or full-credible, the Adjusted MLR is compared to the MLR Standard.
- D) If the Adjusted MLR is greater than or equal to the MLR Standard, then the Health Plan meets the MLR Standard and no remittance is required.
- E) If the Adjusted MLR is less than the MLR standard, then the Health Plan does not meet the MLR Standard and may be subject to a remittance by DHS.

REPORT 106: FRAUD AND ABUSE SUMMARY

106.1 Introduction

- A) The Health Plan shall provide DHS with a summary of Fraud, Waste, and Abuse (FWA) activities that occurred during the reporting period. This includes a summary of Suspected Fraud and Abuse referrals the Health Plan made to the State as well as a summary of cases that did not rise to a level of referral to the State.

106.2 Applicable Contract Sections

- A) Section 6.2.F.8.b (Report Descriptions) describes the requirements of the Fraud, Waste and Abuse Summary Report.
- B) Section 12.1.A.8 (Fraud, Waste and Abuse (FWA)) lists the Fraud and Abuse Summary report as a requirement for Health Plans.

106.3 Terms and Definitions

- A) **Fraud and Abuse Referral:** a formal referral of suspected fraud and abuse using the Suspected Fraud and Abuse (SFA) Referral Report.
- B) **Fraud:** Per 42 CFR §455.2, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
- C) **Abuse:** Per 42 CFR §455.2, provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
- D) **Adverse Actions:** For the purposes of this report, an adverse action is any action the Health Plan takes against a provider, facility, and/or subcontractor as a result of suspected fraud or abuse. Adverse Actions may include, but are not limited to, requiring pre-payment review of claims, conducting an on-site audit, or requiring the provider education on the issue.

- E) **Overpayment:** As defined in 42 CFR §438.2, any payment made to a network provider by a Health Plan to which the network provider is not entitled to under Title XIX of the Act or any payment to an Health Plan by a State to which the Health Plan is not entitled under Title XIX of the Act.
- F) **Verification of Services (VOS):** As defined in 42 CFR § 455.20, verifying with members whether services billed by providers were received. Contract Section 12.2 describes how the Health Plan shall conduct VOS.
- G) **Electronic Visit Verification (EVV):** an electronic system that verifies key information about services provided for personal care services and home health services, implemented by Med-QUEST in response to federal requirements set forth in the 21st Century Cures Act. See QI-1929 and QI-2125 for a list of service codes and modifiers subject to EVV.
- H) **EVV visit:** A distinct visit performed through the EVV system. Sandata maintains a database of EVV visits that are matched to provider claims for verification. An EVV claim may list multiple EVV visits. Health plans can access EVV visit information through Sandata's reporting portal as well as through the EVV visit extract MQD provides on a quarterly basis.
- I) **Category of Service:** As defined by Med-QUEST, the category of service provided to members:
1. **Facility Inpatient:** services recorded on Bill Type 11X, 12X, 18X, 21X, 28X, 41X, or 86X
 2. **Facility Outpatient:** services recorded on Bill Type 13X, 14X, 32X, 33X, 34X, 43X, 61X, 63X, 71X, 72X, 73X, 74X, 75X, 76X, 77X, 79X, 81X, 82X, 83X, 84X, 85X, or 89X
 3. **Professional:** services recorded on a CMS 1500 claim that do not have an HCBS procedure code
 4. **Home and Community Based Services (HCBS):** services recorded on a CMS 1500 with the procedure codes H0045, S5101, S5102, S5105, S5108, S5109, S5110, S5111, S5115, S5116, S5120, S5121, S5125, S5130, S5135, S5140, S5150, S5151, S5160, S5161, S5162, S5165, S5170, S5185, S9122, S9123, S9124, S9125, S9452, T1005, T1019, T2001, T2003, T2004, T2022, T2025, T2028, T2029, T2031, T2033,

T2035, T2038, or T2039

5. **Pharmacy:** services recorded on an NCPDP
6. **Nursing Home/Waitlist:** services recorded on Bill Type 22X, 23X, 65X, or 66X

106.4 Methodology

A) **This report is organized into six sections.**

B) **In Section 1: Program Integrity Compliance,** the Health Plan shall provide information on the Health Plan's compliance with Administrative Requirements listed in Section 12.1. The Health Plan shall provide:

1. The Name and Contact Information of the Health Plan's Compliance Officer
2. The Name(s) and Contact Information of the Health Plan's Compliance Committee members
3. The Name(s) and Contact Information of the staff in the Health Plan's Special Investigative Unit (SIU), limiting this list to those staff who are involved with Med-QUEST SIU activities.
4. The Health Plan shall attest to whether their Compliance Committee met during the reporting period to discuss FWA compliance issues.
5. If the Compliance Committee did meet, the Health Plan shall attach a copy of that meeting's agenda to the report.
6. The Health Plan shall attest to whether any updates were made to the Health Plan's FWA Compliance Plan since the last reporting period.
7. If updates were made, the Health Plan shall attach a copy of the most up-to-date version of the FWA Compliance Plan.

C) **In Section 2: Health Plan SIU Activity,** the Health Plan shall complete the embedded template to provide a list of SIU Cases during the reporting period. The Health Plan shall provide information for all SIU Cases that were either opened or closed during the reporting period. The Health Plan should use the FAS_MLDF_PLDF_1_DataFormat to populate this file.

D) In **Section 3: Summary Narrative of Fraud and Abuse Activities**, the Health Plan shall provide a summary of all fraud and abuse activities undertaken during the reporting period. The Health Plan shall provide the following information:

1. A List of any Program Integrity training provided to Health Plan staff during the reporting period, including Medicaid Fraud
2. Control Unit (MFCU) trainings, webinars, or other trainings on FWA detection and investigation activities;
3. A list of specific activities the Health Plan has conducted to review providers' provision of services during the reporting period.

E) In **Section 4: Verification of Services (VOS)**, the Health Plan shall provide a summary of their quarterly Verification of Services activities.

1. The Health Plan shall use an embedded template to provide information on the Health Plan's Verification of Service (VOS) activities during the reporting period. The Health Plan shall calculate the number of members who received services by the defined Categories of Service during the reporting period, and of those members, how many members were sent VOS. In addition, the Health Plan shall calculate the overall total of unduplicated members across all Categories of Service that received VOS.
2. The Health Plan shall attest whether the members who received VOS included a random selection of recipients by Category of Service;
3. The Health Plan shall attest to whether the VOS were mailed to members within forty-five (45) days after the claim was submitted.
4. For instances where VOS identified services that were not delivered, they will describe the steps taken to resolve the situation.

F) In **Section 5: Electronic Visit Verification (EVV)**, the Health Plan shall provide a summary of their EVV activity for the reporting period.

1. The Health Plan shall use an embedded Excel file to provide information on the Health Plan's Electronic Visit Verification (EVV) activities during the reporting period based on Sandata EVV visits.

G) In **Section 6: Specific Information on Fraud and Abuse Referrals**, the Health Plan shall complete an embedded Excel file that provides a summary of each Suspected Fraud and Abuse Referral made to the State during the reporting period. The Health Plan shall refer to FAS_ALDF_4_DataFormat for a list of data elements reported in this section.

106.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. The Health Plan's Compliance Committee met in the past quarter to discuss FWA compliance issues
2. Percent of cases referred to the State within 14 days of determining suspected fraud or abuse.
3. Percent of members who received VOS from the Health Plan.
4. Percent of manually edited EVV visits that the Health Plan reviewed.

REPORT 107: PRESCRIPTION DRUG REBATES

107.1 Introduction

- A) The Health Plan shall provide a monthly report on drug utilization for all covered outpatient drugs eligible for rebates through the Medicaid Prescription Drug Rebate Program, excluding drugs that are subject to the 340B drug pricing program.
- B) The Health Plan shall provide an annual summary of Drug Rebates received over the year.

107.2 Applicable Contract Sections

- A) Section 6.2.F describes the Prescription Drugs Rebate Report.
- B) Section 4.5.B.16 describes the requirement for the Health Plans to report drug utilization data necessary for the States to bill manufacturers for rebates per CFR §438.3(s)(1).

107.3 Terms and Definitions

- A) **CMS Medicaid Drug Rebate Program:** The Medicaid Drug Rebate Program (MDRP) is a program that includes Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, and participating drug manufacturers that helps to offset the Federal and state costs of most outpatient prescription drugs dispensed to Medicaid patients. For a current list of these manufacturers please refer to the CMS Medicaid Drug Rebate Program website: <https://data.medicaid.gov/dataset/0ad65fe5-3ad3-5d79-a3f9-7893ded7963a>.
- B) **Drug Product Data:** <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/recordspecficationanddefinitions.pdf>.
- C) **340B Drug:** a drug purchased through the 340B program, a national program that allows providers to purchase medications at discounted rates. Health Plans shall identify drugs subject to discounts under the 340B program in two ways:
 - 1. For covered entities, the Health Plans shall refer to the most recent HRSA

list (<https://340bopais.hrsa.gov/Reports>) to ensure prescriptions filled by these entities are removed from the extracts.

2. For contracted pharmacies, the Health Plans shall refer to the 340B indicator field is available in the Claim Billing (B1) transaction in the field Submission Clarification Code (420-DK) with the value of 20:

Field	Value	Description
Submission Clarification Code (420-DK)	20	340B – Indicates that, prior to providing service, the pharmacy has determined the product being billed is purchased pursuant to rights available under Section 340B of the Public Health Act of 1992 including sub-ceiling purchases authorized by Section 340(a)(10) and those made through the Prime Vendor Program (Section 340(a)(8))

3. The Health Plan may refer to Memo QI-1715/CCS-1703 for further information.

- D) **Rebate Unit:** The number of units (based on Unit Type) of the 11- digit NDC dispensed during the period covered. For pharmacy claims on the NCPDP form, this is often the same as the NCPDP unit.
- E) **Aged, Blind, Disabled (ABD) and Family and Children and Expansion (FCE):** Groupings used for the Annual Drug Rebate Summary file based on capitation rate code. Refer to “ABD-FCE Cross-walk.xlsx” in this report’s subfolder within the “Report Reference Tables and Data Submission

Formats" folder.

F) **Pharmacy Benefits Manager (PBM):** the third-party administrator of prescription drug programs

G) **Exclusions**

1. **Exclusion 1:** Prescription drug claims for any State Funded Populations.

F21 - PRESUMPTIVE TIMELINESS - QUEST
F22 - PRESUMPTIVE TIMELINESS - QEXA
G02 - REFUGEE
H04 - STATE FINANCIAL - GENERAL ASSISTANCE
H05 - STATE FINANCIAL - AGED
H06 - STATE FINANCIAL - BLIND
H07 - STATE FINANCIAL - DISABLED
H08 - STATE FUNDED PENSIONERS
H38 - REPATRIATE
H49 - STATE BREAST CANCER
H51 - STATE CERVICAL CANCER
H83 - STATE FINANCIAL - AGED
H91 - BASIC HEALTH HAWAII
H93 - COFA BHH
S01 - STATE FUNDED AGED COFA
S02 - STATE FUNDED BLIND/DISABLED COFA
S03 - STATE FUNDED AGE NON CITIZEN < = 60 MO
S04 - STATE FUNDED BL/DI NON-CITIZEN < = 60 MO
S06 - STATE FUNDED EMGNCY/SPECIAL ENROLL

2. **Exclusion 2.** Prescription drug claims where Health Plan ID in (HMSAAA, XHMSAA, ALOHAC, XALoha, UNITED, XUNITD, OHANAA, XOHANA, OHANABH, KAISER, XKASIR); AND Diagnostic Code contains (Z33.2, O04.80, O04.89, O07.30, O07.39, O07.4); OR Procedure Code contains (S0190, S0191, S0199, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857)

3. **Criteria:** Exclusions 1 and 2 are effective for all claims with dates of services beginning 7/1/2025.

4. **Exclusion 3.** All claims with the following provider IDs in any provider field/capacity (e.g. billing provider, prescribing provider, servicing

provider, etc.):

- a. 804676
- b. 005695

5. Criteria for Exclusion 3:

- a. If Service Date < 07/01/2025, then include the claim;
 - b. Else if Service Date > 06/30/2025 and Health Plan Paid Date < 09/11/2025 then include the claim;
 - c. Else if Service Date > 06/30/2025 and Health Plan Paid Date > 09/10/2025 then exclude the claim
6. MQD reserves the right to update this list and any requirements outside the Health Plan Manual amendment process. These will be communicated via email and formally incorporated in a subsequent amendment. Health Plans will be expected to incorporate those changes per guidance outlined in the email and may include both prospective and retrospective PDR submissions.

107.4 Methodology

A) This report is organized into three sections.

B) In Section 1: Medicaid Drug Rebate Program, the Health Plan shall provide a monthly extract containing claims data on all covered outpatient drugs prescribed during the reporting period eligible for a refund under the CMS Medicaid Drug Rebate Program, excluding drugs subject to discount under the 340B drug pricing program.

- 1. The Health Plan shall provide the data elements described in "PDR_MLDF_DataFormat.xlsx." file in this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder.
- 2. The Health Plan shall complete the data extract file in the report template.
- 3. The Health Plan shall ensure this extract excludes all drugs that are subject to discounts under the 340B drug pricing program.

4. The Health Plan shall ensure that units reported (num_of_units) for each drug is converted into the appropriate Rebate Units as required by this report.

C) In **Section 2: Assessment of Methods** used to pull drug extracts the Health Plans shall provide a quarterly attestation of the methods used to extract the data in Section 1. These methods include:

1. Did the Health Plan exclude 340B drugs from the extracts based on the list of covered entities published by HRSA or the 340B flag populated by contracted pharmacies?
2. Did the Health Plan ensure the units provided in the extract are the appropriate Rebate Units as defined for this report?

D) In **Section 3: Annual Drug Rebate Summary**, the Health Plan shall provide an annual summary of all actual drug rebates received by two Rate Code Groups: ABD and FCE. The Health Plan shall not include any anticipated drug rebates in these totals.

E) In **Section 4: Health Plan PBM Contracts**, the Health Plan shall provide DHS with additional information on the cost structure of their Pharmacy Benefits Manager contract.

107.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. Number of 340B drugs present in the Medicaid Drug Rebate Program extract.
2. The Health Plan attested to excluding 340B drugs based on the list of covered entities published by HRSA or flagged by contracted pharmacies.
3. The Health Plan attested to ensuring the units provided in the extract are the appropriate Rebate Units.

REPORT 108: QUEST INTEGRATION FINANCIAL

108.1 Introduction

- A) This report monitors the Health Plan's overall financial health and solvency through key metrics such as risk-based capital and underwriting ratios. Additionally, this report identifies any protected health information breaches and resulting financial penalties.

108.2 Applicable Contract Sections

- A) Section 15.2.E (Risk-based Capital Report) describes the required risk-based capital report submission.
- B) Section 6 (Reports) outlines the required QUEST Integration Financial report per 42 CFR §438.3(m) and 42 CFR §438.604 and to ensure fiscal solvency per 42 CFR §438.116.

108.3 Terms and Definitions

- A) **Underwriting Ratio (UW):** This represents the proportion of revenue that was "left over" to fund the Health Plan's surplus and profit after funding medical and administrative costs. This is calculated by dividing the net underwriting gain or (loss) by total revenue multiplied by 100%.
- B) **Risk-based Capital Ratio (RBC):** the proportion of the required minimum capital that is held by the Health Plan as of a specific date. This represents the total adjusted capital divided by the authorized control level multiplied by 100%.
- C) **Return on Investment Capital (ROIC):** This metric measures the return (underwriting gain or loss) relative to the investment (risk-based capital). This is calculated by dividing the underwriting gain or loss by the risk-based capital held by the plan multiplied by 100%.
- D) **Combined Ratio (CR):** This metric represents the underwriting profitability of the Health Plan. This is the total underwriting deductions divided by the total revenue multiplied by 100%.

108.4 Methodology

- A) **This report is organized into four sections.**

B) In **Section 1: Risk-Based Capital Report**, the Health Plan shall report and calculate several metrics related to risk-based capital as of the time of submission of this report. These metrics include:

1. Total adjusted capital, post-tax
2. Authorized Control Level = 100% of Authorized Control Line
3. Total Revenue
4. Underwriting Deductions
5. Combined Ratio
6. RBC Ratio

The Health Plan shall also attach a copy of their most recent risk-based capital report. The risk-based capital report is filed with Health Plan's NAIC annual statement.

C) In **Section II: Fiscal Solvency**, the Health Plan shall provide additional metrics on fiscal solvency and answer several related questions. The Health Plan shall report on the following:

1. If the Health Plan is aware of any impending changes to its financial structure that could adversely impact its ability to pay its debts as they come due generally
2. If the Health Plan has filed for protection under state or federal bankruptcy laws
3. If the Health Plan's property, plant, or equipment has been subject to foreclosure or repossession with the preceding ten (10)-year period.
4. If the Health Plan had any debt called prior to expiration within the preceding ten (10)-year period.
5. The Health Plan shall report their net underwriting gain or (loss) from the past quarter. The Health Plan shall also copy the Total Revenue reported in row 3, Table 1. The UW ratio is then calculated as the total revenue divided by the net underwriting gain or loss multiplied by 100%.

6. The Health Plan shall also provide and calculate metrics related to ROIC. The Net Underwriting Gain or Loss will be copied over from row 1, table 2. The Total Adjust Capital will be copied over from row 1, table 1. The ROIC is the net underwriting gain or loss divided by the total adjusted capital.

D) In **Section III: Protected Health Information Breaches**, the Health Plan shall report if they identified any breaches of protected health information (PHI). These include any events identified regardless how far back the breach occurred. If the Health Plan reports that there was/were breach(es) of PHI, then the Health Plan shall provide additional information in the embedded worksheet titled "QFG_ALDF."

1. Date of breach
2. Did the breach result in the exposure of PHI?
3. Where did the exposure occur? (e.g. internal, subcontractor)
4. How many individuals' data were included in the breach?
5. How many individuals' data were included in the breach?
6. How many total record of data were breached?
7. To what extent was the breached data seen or used?
8. Were there any financial sanctions or penalties?
9. If financial penalties, describe the dollar amount.

E) In **Section IV: Patient Access**, the Health Plan shall report on basic usage metrics for the Patient Access API and provide links to required publicly accessible information in their annual submission. Plans must document how many members used the API at least once or multiple times, and supply URLs for the Patient Access API itself along with member-facing educational materials for the Patient Access, Provider Access, and Payer-to-Payer APIs in the yearly submission.

108.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. Risk-based Capital Ratio (RBC)
2. Combined Ratio (CR)
3. Underwriting Ratio (UW)
4. Return on Invested Capital (ROIC)

REPORT 109: THIRD PARTY LIABILITY COST AVOIDANCE

109.1 Introduction

- A) The Health Plan shall submit a Third Party Liability (TPL) Cost Avoidance Report to DHS to provide an overview of cost avoidance activities and a complete list of all members with TPL coverage.

109.2 Applicable Contract Sections

- A) Section 6.2.F includes the TPL Cost Avoidance Report.
- B) Section 7.3 describes Health Plan responsibilities related to TPL, including reporting requirements.

109.3 Terms and Definitions

- A) **Coordination of Benefits:** The act of determining respective payment responsibilities between Health Plans when a member has coverage through more than one insurance plan.
- B) **Coordination of Benefits Collections:** The total amount of money recovered on services where Medicaid was the primary payer, but the member had TPL coverage. This amount should reflect the recoveries flagged as "COB" listed on the quarterly Health Plan Overpayments Report to DHS.
- C) **Coordination of Benefits Cost Avoided Amount:** The total amount of cost avoided due to Coordination of Benefits where a member's non-Medicaid insurance plan was the primary payer.
- D) **Accident Liability Recoveries Collections:** The total amount collected for accident and worker's compensation subrogation benefits. DHS shall be responsible for coordination and recovery of accident and worker's compensation subrogation benefits.
- E) **Accident Liability Recoveries Cost Avoided Amount:** The total amount of cost avoided due to coordination and recovery of accident and worker's compensation subrogation benefits.
- F) **Third Party Liability (TPL):** Any non-Medicaid health insurance plan or carrier (i.e., individual, group, employer-related, self-insured or self-funded,

or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the health care expenses of the member.

- G) **Rate Code Group:** Groupings used for Coordination of Benefits Cost Savings tabulation based on capitation rate code. For a cross-walk of capitation rate code Rate Code Group, refer to the "APD- FCE Crosswalk.xlsx" in this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder.
- H) **TPL Status:** Whether a member has Third Party Liability through commercial or Medicare insurance.
1. TPL Member
 2. Non-TPL Member
- I) **Member Month:** calculated by taking the number of individuals enrolled in a plan and multiplying that sum by the number of months in the policy. For the TPL Cost Avoidance Report, please calculate Member Month by quarter (e.g., maximum of three months per member). This may not be a whole number due to policies that do not cover a member for a full month; in this case, member month may be a decimal.
- J) **Category of Service:** As defined by Med-QUEST, the category of service provided to members:
1. **Facility Inpatient:** services recorded on Bill Type 11X, 12X, 18X, 21X, 28X, 41X, or 86X
 2. **Facility Outpatient:** services recorded on Bill Type 13X, 14X, 32X, 33X, 34X, 43X, 61X, 63X, 71X, 72X, 73X, 74X, 75X, 76X, 77X, 79X, 81X, 82X, 83X, 84X, 85X, or 89X
 3. **Professional:** services recorded on a CMS 1500 claim that do not have an HCBS procedure code
 4. **Home and Community Based Services (HCBS):** services recorded on a CMS 1500 with the procedure codes H0045, S5101, S5102, S5105, S5108, S5109, S5110, S5111, S5115, S5116, S5120, S5121, S5125, S5130, S5135, S5140, S5150, S5151, S5160, S5161, S5162, S5165,

S5170, S5185, S9122, S9123, S9124, S9125, S9452, T1005, T1019, T2001, T2003, T2004, T2022, T2025, T2028, T2029, T2031, T2033, T2035, T2038, or T2039

5. **Pharmacy:** services recorded on an NCPDP
6. **Nursing Home/Waitlist:** services recorded on Bill Type 22X, 23X, 65X, or 66X

109.4 Methodology

A) **This report is organized into four sections.**

B) **The Health Plans shall complete Section 1: Monthly TPL Cost Avoidance monthly.** In this section the Health Plan shall provide an overview of all Collections and Cost Avoided Amounts for Med-QUEST members during the reporting period.

1. The Health Plan shall provide the following summaries:

- a. For Coordination of Benefits Collections: Total Collections Amount; Total Cost Avoided Amount
- b. For Accident Liability Recoveries: Total Collections Amount. Note, DHS shall be responsible for coordination and recovery of accident and worker's compensation subrogation benefits.
- c. Total Cost Avoided Amount

C) **The Health Plan shall complete Section 2: Coordination of Benefits Cost Savings quarterly.** In this section the Health Plan will provide a tabulation of the total Health Plan Paid Amount during the reporting period by 3 dimensions:

1. TPL Status
2. Category of Service
3. Rate Code Group

Definitions

- a. **Non-Medicare Members with Third Party Liability – Total**

Reimbursements (excluding TPL) includes all members who are covered by a QI plan and a non-Medicare third party payer (i.e. commercial). Total reimbursements paid by the QI plan should be reported in this table. Any payments made by the third party payor must be excluded.

b. **Medicare Members with Third Party Liability – Total**

Reimbursements (excluding TPL) includes all members who are covered by a QI plan and a Medicare plan (often referred to as “dual eligibles”). Total reimbursements paid by the QI plan should be reported in this table. Any payments made by Medicare must be excluded.

c. **Non-Medicare Members with Third Party Liability – Total**

Cost Avoidance includes all members who are covered by a QI plan and a non-Medicare third party payer (i.e. commercial). Total cost paid by the third party payer must be reported in this table as cost avoidance.

d. **Medicare Members with Third Party Liability – Total Cost**

Avoidance includes all members who are covered by a QI plan and a Medicare plan (often referred to as “dual eligibles”). Total cost paid by Medicare must be reported in this table as cost avoidance.

D) **The Health Plan shall complete Section 3: Members with Commercial Insurance quarterly.** In this section the Health Plan shall provide a list of members with commercial insurance:

1. A list of all active members who have commercial insurance with the same or other health plans.
2. For definitions of fields in the reporting template for Section 3, refer to “TPL_MLDF_DataFormat.xlsx” in this report’s subfolder within the “Report Reference Tables and Data Submission Formats” folder.

E) **The Health Plan shall complete Section 4: Members with Medicare Coverage quarterly.** In this section the Health Plan shall provide a list of members with Medicare coverage: A list of all active members who have commercial insurance with the same or other health plans.

109.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. Calculated Cost Savings of Non-Medicare FCE Members (Facility Inpatient)
2. Calculated Cost Savings of Non-Medicare FCE Members (Facility Outpatient)
3. Calculated Cost Savings of Non-Medicare FCE Members (Professional/Other)
4. Calculated Cost Savings of Non-Medicare FCE Members (HCBS)
5. Calculated Cost Savings of Non-Medicare FCE Members (Pharmacy)
6. Calculated Cost Savings of Non-Medicare FCE Members (Nursing Home/Waitlist services)
7. Calculated Cost Savings of Non-Medicare ABD Non-Dual Members (Facility Inpatient)
8. Calculated Cost Savings of Non-Medicare ABD Non-Dual Members (Facility Outpatient)
9. Calculated Cost Savings of Non-Medicare ABD Non-Dual Members (Professional/Other)
10. Calculated Cost Savings of Non-Medicare ABD Non-Dual Members (HCBS)
11. Calculated Cost Savings of Non-Medicare ABD Non-Dual Members (Pharmacy)
12. Calculated Cost Savings of Non-Medicare ABD Non-Dual Members (Nursing Home/Waitlist services)

REPORT 201: COMMUNITY INTEGRATION SERVICES PLUS

201.1 Introduction

- A) The purpose of this report is to monitor the Health Plan's provision of Community Integration Services Plus (CIS+). The data gathered will be used to assess quality of services provided, contract compliance, and evaluation of health outcomes associated with engagement.

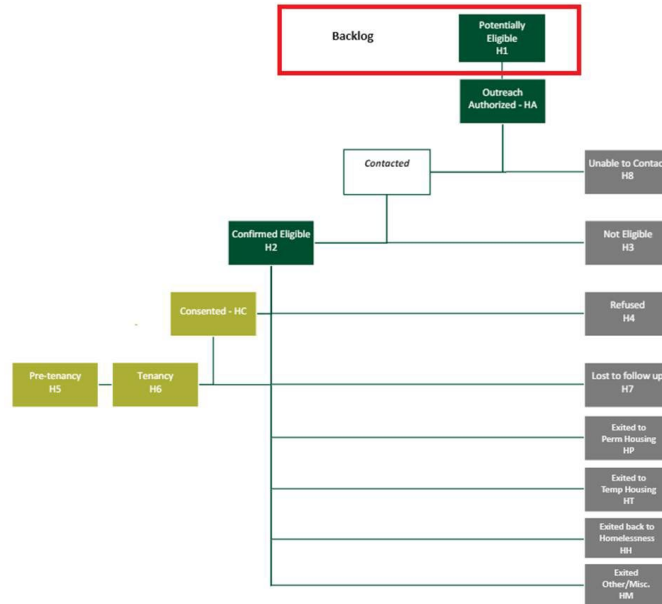
201.2 Applicable Contract Sections

- A) Section 2.1 provides a description of Health Coordination Services the Health Plan should provide for members that meet the CIS+ criteria.
- B) Section 8 provides coverage provisions for Community Integration Services Plus including Housing Navigation and Medical Respite.
- C) Section 8.5.F notifies the Health Plan about DHS reporting requirements for CIS+.

201.3 Terms and Definitions

- A) **All Health Plan members:** Total number of members enrolled in the Health Plan.
- B) **Members newly enrolled in Health Plan:** Number of members newly enrolled in Health Plan during the reporting quarter.
- C) **Potentially eligible for CIS+:** Any member the Health Plan has identified that may be eligible for CIS+ who has not yet gone through eligibility verification or been contacted for consent to participate.
- D) **Newly identified:** Any member that has been identified as potentially eligible for CIS+ within this reporting period.
- E) **New CIS+ member:** Any CIS+ member who the Health Plan identified and confirmed eligible for CIS+ and who gave consent to participate within the reporting period.
- F) **Existing CIS+ member:** Any CIS+ member who was identified, confirmed eligible, and gave consent to participate prior to the reporting period, and who was not disenrolled from the program prior to the reporting period.

- G) **CIS+ members (New and Existing):** All members enrolled in CIS+ services that have been deemed eligible and consented to participate.
- H) **CIS+ services:** Include all pre-tenancy and tenancy services provided to CIS+ members under the CIS+ program.
- I) **Transitional care:** Defined as transitional care management services provided to the member when the member transitions from an acute care setting (such as hospitals, skilled nursing facilities, etc.) back into the community.
- J) **Homeless service provider (HSP):** An organization, external to the Health Plan and contracted by the Health Plan, that provides tenancy and/or pre-tenancy services, including case management, financial, and other wraparound services. If a member has had multiple HSPs during a reporting period, the plan should report on the member's most recent provider, or the provider at the end of the reporting period.
- K) **Backlog:** Only members with the open H1 status code are considered "Backlog"
1. The "Backlog" reference in the CIS+ quarterly report will be updated with the specific H1 code.
 2. The H1 code needs to have start-date e.g. 01/01/2020
 3. The H1 code would have an open end-date indicated by using "12/31/2299"
 4. The backlog includes ALL members for all time. e.g. if the H1 code was sent to MQD in 2020 and has an open end-date, then the member is still being counted in all reports.



Data File Transaction Example

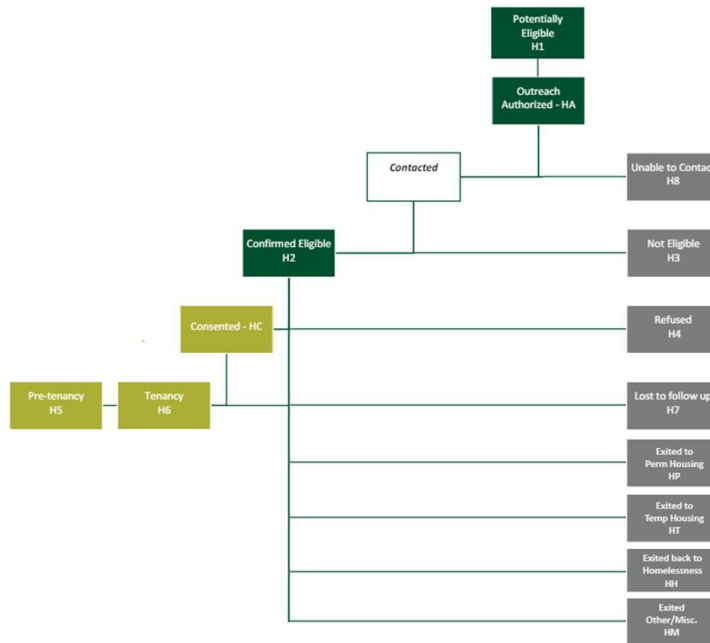
HMSAAA0000123456H12021070720231101

HMSAAA0000123456HA2023110212312299

L) Ongoing Member H Code Updates

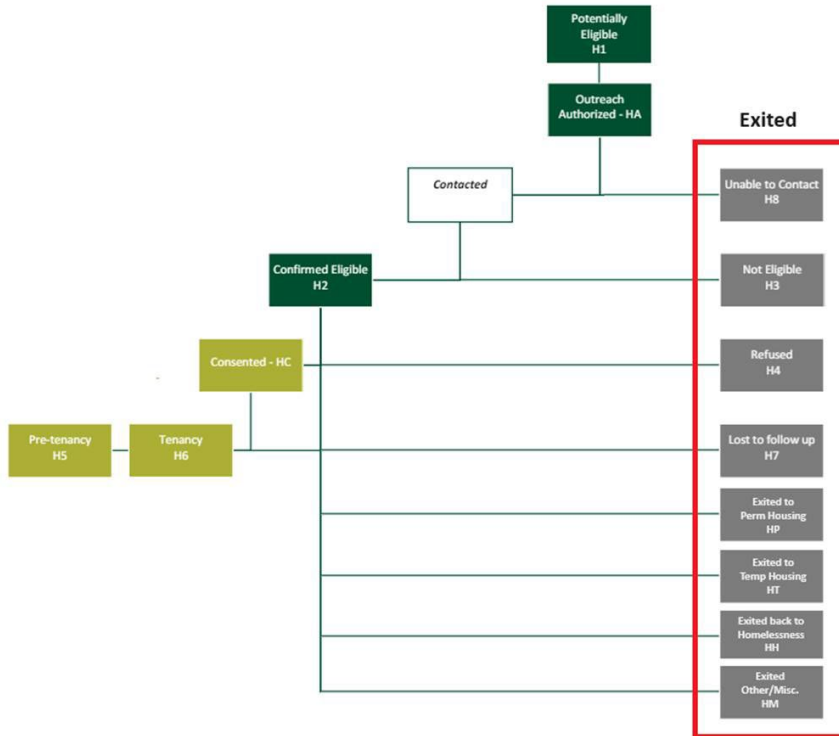
1. When a member moves to a new status then:
 - a. The old H code needs to be updated with an end-date
 - b. A new status code needs to be added
 - c. HPMMIS does not automatically end-date old H codes, if a new H code is sent without closing out the prior H code, then HPMMIS will reject the record with an error code.
 - d. The MCOs need to review the error codes sent back on rejected records
 - e. Memo QI-2003 contains the process/instructions that the MCOs need to follow
 - f. Member was Potentially Eligible "H1" and then Outreach Authorized "HA"
 - g. H1 start-date 1/1/2024 end-date 12/31/2299 1/31/2024

h. HA start-date 2/1/2024 end-date 12/31/2299



M) **Member Exiting CIS+**

1. To ensure proper CIS+ reporting/calculation, members that leave the CIS+ program need to have exit codes assigned with end-dates.
2. When a member no longer receives CIS+ services:
3. The old H code needs to be updated with an end-date
4. A new exit status code needs to be added (E.g. Member was Outreach Authorized "HA" and then was not found "Unable to Contact" "H8".)
5. HA start-date 2/1/2024 end-date 3/1/2024
6. H8 start-date 3/2/2024 end-date 3/3/2024



201.4 Methodology

A) This report is organized into two sections.

1. In Section 1, the Health Plan shall provide a data file, "Integrated CIS+ Report Template," that contains three datasheets: the Member-Level Data File (MLDF), the Assessment Plan Level Data File (ASLDF), and the Action Plan Level Data File (APLDF). These files will contain all Member-Level Data.
2. In Section 2, the Health Plan shall provide the CIS+ Qualitative Data Collection Component (QDCC).

B) Section 1: Integrated CIS+ Report Template

1. Data Sources:

- a. The Health Plan will report member-level data from a number of sources. In addition to the Health Plan's administrative records, CIS+-specific sources for each metric are included in the MLDF, ASLDF, and APLDF. These include:

- 1) CIS+ Referral

- 2) CIS+ Consent
- 3) CIS+ Assessment
- 4) CIS+ Action Plan

b. There are metrics which health plans are required to complete that are not represented in the CIS+-specific forms listed above. The source for this data, per the "Data Submission Format" tab, is listed as "Specific services provided to be captured by health plan." Health Plans may use their own definitions for these services, and they are not required to align to Health Coordination Service categories or activities reported in the Health Coordination Services Plus Report. Health Plans may work jointly, and as needed with support from MQD, to develop reporting mechanisms to support meeting these requirements.

C) CIS+ Health Action Plan Addendum Data Collection/Reporting:

1. The Health Plan shall report on CIS+ services that have been implemented for each new CIS+ member and existing CIS+ members. The MLDF shall include all members with an open H code at any time during the reporting period, including those whose H codes closed during the reporting period.
 - a. Members with an open H code have been assigned an H code and have an H-code with an end date of 12/31/2299.
 - b. Members with a closed H code have been assigned an H code that has a known end date and no other H code has been assigned to that member. Members with an end date during the reporting period should be included in the MLDF.
2. The ASLDF and APLDF shall include Assessment and Action Plan data from members who have been assigned H5 or H6 at any point on or after the February 1, 2024 implementation of the new Assessment and Action Plan forms. Going forward, health plans will be expected to report 3 rolling years backwards, with the first Assessments and Action Plans reported on the ASLDF and APLDF having occurred on or after the February 1, 2024. Records that are over 3 years old do not need to be reported in the APLDF or ASLDF.

3. Members can only be assigned to H5 or H6 if they are receiving tenancy or pre-tenancy services. Members who are approved to receive tenancy or pre-tenancy services but are not yet receiving services shall not be included in H5 or H6. Members who have been determined to be eligible but who have not received services must be classified as H2. Health plans should examine all current CIS+ members with open H5 or H6 codes and provide an end date of October 14, 2023 for those members who are not receiving and have never received tenancy or pre-tenancy services. This end date will signal that these members were assigned H5 or H6 in error. Health plans are expected to correct these errors by February 1, 2024.
4. The report shall exclude services related to Member enrollment in Long Term Services and Supports and Special Health Care Needs.
5. The "CIS+ Report Template" file which includes the MLDF, ASLDF, and APLDF will be used to evaluate CIS+ member outcomes by assessing member-level data.
 - a. The first members represented in the MLDF will have been assessed on or after February 1, 2024, which is the date of implementation for the revised CIS+ forms.
 - b. The ASLDF shall be updated quarterly and include complete Assessment or Re-Assessment data for members who have consented within the past 75 days. Every assessment and re-assessment should have its own row. Upon implementation of the ASLDF, plans are expected to maintain an additive file which includes all members who have been assessed in the past 3 rolling years and any re-assessments.
 - c. The APLDF shall be updated quarterly and include complete Action Plan data for members who have consented within the past 75 days. Action Plans are expected to be reviewed and updated every 3 months. Revised Action Plans must be included on a separate row. For example, a member who has been in the program for 12 months should have 4 Action Plans (1 initial and 3 updated). Upon implementation of the APLDF, plans are expected to maintain an additive file which includes all members who have had an Action Plan in the past 3 rolling years.

- d. When reporting data in the MLDF, ASLDF, and APLDF, Health Plans should follow guidance for naming each variable and coding responses using the reference table found in the "Data Submission Format" tab of the "CIS+ Report Template" file. The "Data Submission Format" tab of the "Integrated CIS+ Report Template" file provides data source, formatting, description, and coding information for each MLDF, ASLDF, and APLDF data field.
- e. The primary data sources for the MLDF are "CIS+ Referral Form," "CIS+ Consent Form," "Health Plan Administrative Records," and "Claims and Encounters."
- f. When reporting in the MLDF, ELIG_REDET refers to whether the member was eligible for redetermination during the reporting period and ELIG_REDET_REM refers to whether member remained in the CIS+ program during the reporting period.
- g. The primary data source for the ASLDF is "CIS+ Assessment."
- h. The primary data source for the APLDF is "CIS+ Action Plan."
- i. Health Plans have 30 days upon the completion of referral form, consent form, and any other forms received from the HSP to include this data in the report. Delays on behalf of HSPs do not change this expectation.
- j. For the MLDF, ASLDF, and APLDF, Health Plans shall report any new and current data available for that reporting period, including data that was collected in previous quarters. Health plans are expected to update data from any CIS+ Assessments and CIS+ Action Plans within 30 calendar days of the Assessment or Action Plan update's completion.
- k. For LASTCAP_DATE, CAP_DATE_INIT and CAP_DATE_COMP in the MLDF, please follow the logic below. The goal is for MQD to capture the time between action plans.
 - 1) If the member has completed a CAP during the reporting period, plans must enter the date the CAP was begun for CAP_DATE_INIT and enter the date completed for

CAP_DATE_COMP. If the CAP is the first initial CAP completed by the member, plans must enter "1" for CAP_TYPE. If the CAP is not the first CAP, plans must enter "2" for CAP_TYPE.

2) If CAP_TYPE=2, plans must report the previous CAP completion date in LASTCAP_DATE.

iii If CAP_TYPE = 1, plans will only report the CAP_DATE_INIT and CAP_DATE_COMP and leave LASTCAP_DATE blank.

iv If member has not completed a CAP during the quarter, then plans must enter the date of the most recent CAP, if applicable, in LASTCAP_DATE.

D) **In Section 2**, the Health Plan shall provide descriptive details about the Health Plan's CIS+ implementation and challenges during the reporting period. These qualitative questions may be found in the report template document.

201.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance:

1. The Health Plan has an active and ongoing data exchange process and/or data sharing agreement with the Homeless Information Management System (HMIS) and/or the Coordinated Entry System (CES) to identify members who are potentially eligible for CIS+, and/or track CIS+ members' prioritization for Housing Expense Supports.
2. Health Plan has completed 100% of fields for members who consented over 75 calendar days prior to report submission.
3. Percent of members potentially eligible for CIS+ within reporting period identified through Health Plan analytics and internal referrals.
4. Percent of members with eligibility confirmation during the quarter within the allowed window (30 days).
5. Percent of members who consented during the quarter to participate in CIS+ within 10 days of eligibility confirmation.

6. Percent of members within the reporting period who declined participation in CIS+.
7. Percent of new CIS+ members within the reporting period who completed their initial assessment within 15 days of consent.
8. Percent of existing CIS+ members who received a CIS+ Re-Assessment/Plan Review and Update within 90 days.
9. Percent of CIS+ members who were due for Medicaid eligibility re-determination who remained in Medicaid on the last day of the reporting period.
10. Percent of CIS+ members who transitioned from pre-tenancy to tenancy.
11. Percent of CIS+ members who were lost to follow up.
12. Percent of members who have been in the CIS+ program for at least 6 months and have received a routine checkup with a PCP in the year prior to the first day of the reporting period.
13. Percent of CIS+ members whose Assessments / CIS+ Action Plans were shared with their PCP during the quarter.
14. Percent of existing CIS+ members with two or more hospitalizations in past 3 months.
15. Percent of existing CIS+ members with two or more ER Visits in past 3 months.

REPORT 202: EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT

202.1 Introduction

- A) The purpose of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report is to monitor the quality and quantity of EPSDT services provided to eligible members.

202.2 Applicable Contract Sections

- A) Section 6.2.E.2 (Report Descriptions) describes the requirements of the EPSDT Report.
- B) Section 5.1.D.2 (Performance Measures) describes the required EPSDT data.

202.3 Terms and Definitions

- A) **Total individuals Eligible for EPSDT:** The total number of unique individuals less than 21 years of age enrolled in Medicaid or CHIP expansion program determined to be eligible for an EPSDT visit during the reporting period. The age group and basis of eligibility will be determined as of the last day of the reporting period.
- B) **Total individuals eligible for EPSDT for 90 Continuous Days:** The total number of unique individuals in (A) that were eligible for EPSDT for 90 continuous days or more.
- C) **Total Individuals Eligible Under a CHIP Medicaid Expansion:** The total number of individuals in that were eligible under CHIP.
- D) **State Periodicity Schedule:** A predetermined schedule of EPSDT required to be conducted for a specific age group. The current periodicity schedule is referenced in Part II (Operational Guidance).
- E) **Annualized State Periodicity Schedule:** The expected number of screenings expected to be received by an individual in each age group in one year.
- F) **Total Months Eligible:** The total number of months members in (B) were eligible for EPSDT. The total months of eligibility will be reported in the age

category where the individual is reported even if the individual spans across two age categories during the reporting period.

- G) **Average Period of Eligibility:** This is equal to the total months of eligibility (F) divided the total number of individuals eligible for EPSDT for 90 continuous days (B) and then dividing by 12. This represents the portion of the reporting period the individual remained eligible.
- H) **Expected Number of Screenings per Eligible:** This is equal to the Annualized State Periodicity Schedule (E) (for Annual Reports) multiplied by the Average Period of Eligibility (G). This reflects the expected number of EPSDT furnished per individual per reporting period.
- I) **Expected Number of Screenings:** This is equal to the Expected Number of Screenings per Eligible (H) multiplied by the Total individuals eligible for EPSDT for 90 Continuous Days. This reflects the total number of screenings expected to be furnished to eligible individuals in (B).
- J) **Total Screens Received:** The total number of initial or periodic EPSDT furnished to eligible individuals from (B). Screening data is reported in the age category reflecting the individual's age as of the last day of the reporting period even if they individual spanned across two age categories.
- K) **Screening Ratio:** This is equal to the Total Screens Received (J) divided by the Expected Number of Screenings (B).
- L) **Total Eligibles Who Should Receive at Least One Initial or Periodic Screen:** This is equal to the Expected Number of Screenings per Eligible (D) multiplied by Total individuals eligible for EPSDT for 90 Continuous Days (B). If the number is greater than 1 then the number 1 will be used.
- M) **Total Eligibles Receiving at Least One Initial or Periodic Screen:** The unique number of individuals from (B) who received one or more EPSDT screenings.
- N) **Participant Ratio:** This is equal to Total Eligibles Receiving at Least One Initial or Periodic Screen (M) divided by Total Eligibles Who Should Receive at Least One Initial or Periodic Screen (L). This indicates the extent to which eligible are receiving ESPDT screenings.
- O) **Total Eligibles Referred for Corrective Treatment:** Number of unique

individuals from (B) who had paid, unpaid, or denied claim(s) for a visit/service that occurred within 90 days from the date of an initial or periodic screening within the reporting period where none of the claim contains: capitation payments, administrative fees, transportation services, nursing home services, ICF-MR services, HIPPA payments, inpatient services, dental care, home health services, long-term care services, or pharmacy services.

- P) **Total Eligibles Enrolled in Managed Care:** The number of unique individuals from (B).
- Q) **Total Number of Screening Blood Lead Tests:** The total number of blood lead tests provided to eligible individuals under the age of six from (B). This does not include follow-up blood tests performed on individuals in (B) who have been diagnosed or are being treated for lead poisoning.
- R) **Methodology Used to Calculate the Total Number of Screening Blood Lead Tests:** This includes a combination or using one of the following two methods:
1. CPT Code 83655
 2. HEDIS measure associated with blood lead screenings
- S) **Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider:** Number of Eligibles in (B) that received oral health services, such as fluoride varnish, from a non-dentist provider.
- T) **Total individuals eligible for EPSDT for 30 Continuous Days:** The total number of unique individuals in (A) that were eligible for EPSDT for 30 continuous days or more.
- U) **Total individuals eligible for EPSDT who have a behavioral health (BH) diagnosis:** the unique number of individuals who have a BH diagnosis indicated in Dx codes. Please include primary and secondary diagnoses.
- V) **Total individuals eligible for EPSDT who have a behavioral health (BH) diagnosis and who are receiving BH services:** The unique number of individuals who have a BH diagnosis who are receiving BH services. Please include primary and secondary diagnoses.

202.4 Methodology

- A) The Health Plan shall complete the Data Collection worksheets embedded in the Report.
- B) Both annual and quarterly reports will be completed on the sample template, however, the February submission of the EPSDT will be used to complete CMS Form 416.
- C) Reports will be submitted on the following schedule:

Reporting	Reporting Period	Deadline for Submission
Quarterly	1/1 – 12/31	1/31
Quarterly	04/01 – 03/31	04/30
Quarterly	07/01 – 06/30	07/31
Quarterly	10/01 – 09/30	10/31
Annual	10/01 – 9/30	02/28

- D) The Health Plan shall provide required EPSDT data by island in their respective tab. The “Statewide” tab will automatically sum the data reported by island. All grey fields do not require any inputted data.
- E) All measures are disaggregated by eligibility status (i.e., Categorically Needy and Medically Needy) and age group (e.g., <1 years).
- F) The Health Plan will enter data for each of the following measures using the measure definitions provided above. Additional information on these measures can be found here:
<https://www.medicaid.gov/medicaid/benefits/downloads/cms-416-instructions.pdf>
 - 1. Total Individuals Eligible for EPSDT
 - 2. Total Individuals Eligible for 90 Continuous Days
 - 3. Total Individuals Eligible Under a CHIP Medicaid Expansion
 - 4. Total Months of Eligibility
 - 5. Total Screens Received
 - 6. Total Eligibles Receiving at Least One Initial or Periodic Screen

7. Total Eligibles Referred for Corrective Treatment
8. Total Eligibles Enrolled in Managed Care
9. Total Number of Screening Blood Lead Tests
10. Methodology Used to Calculate the Total Number of Screening Blood Lead Tests
11. Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider

202.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs submitted as part of quarterly reports to evaluate Health Plan performance.

1. Percent Eligible Receiving EPSDT Screenings: the participant ratio for the whole state.
2. Percent Eligible Receiving EPSDT By Island: The participant ratio by island.
3. Percent Eligible Receiving EPSDT by age group: The participant ratio by age group
4. Provider Notification of Past Due EPSDT: The Health Plan has a mechanism (e.g., EHR alert, EHR report, notice) by which their providers are notified of their members past due for EPSDT.
5. Member Notification of Past Due EPSDT: The Health Plan has a mechanism by which they notify parents/ legal guardians/ caretakers of members past due for EPSDT

REPORT 204: GOING HOME PLUS

204.1 Introduction

- A) The purpose of this report is to monitor the Health Plan's provision of Going Home Plus (GHP) to members enrolled in the program. The data gathered will be used to assess the quality of services provided, contract compliance, and evaluation of cost outcomes associated with engagement. GHP SAR will be submitted semi-annually and GHP QFR will be submitted quarterly.

204.2 Applicable Contract Sections

- A) Section 3.7 (Health Coordination Services) contains a description of Health Coordination Services (HCS) and the populations eligible for these services.
- B) Section 3.7.D contains the Health Plan's responsibilities for GHP populations.
- C) Section 6.2.E.2 (Covered Benefits and Services) includes the GHP report.

204.3 Terms and Definitions

- A) **GHP members:** LTSS members who are enrolled in GHP.
- B) **Members Newly Entering GHP and New GHP Members:** Members who entered GHP during the current reporting period, and who were not previously enrolled in GHP. Members who were previously in GHP but had a gap of 90 days or longer since their previous GHP status was terminated may be considered "newly entering GHP." The Health Plan shall also consider members already in GHP but transitioning to the Health Plan from another Health Plan as "newly entering GHP."
- C) **Existing GHP members:** Members who were already enrolled in the Health Plan's GHP program on the first day of the reporting period. A member is considered to be "enrolled" in GHP if the Health Plan has received consent from the member to begin GHP services.
- D) **The Transformed Medicaid Statistical Information System (T-MSIS):** T-MSIS is a reporting system for State Medicaid Agencies. Data on all members in GHP are reportable to CMS via T-MSIS. Therefore, claims and expenditures that were not submitted to HPMMIS must be reported in this

report in T-MSIS Format. The latest T-MSIS data dictionary may be found here: <https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/t-msis-data-dictionary/index.html>. Health Plans shall check to ensure that they are using the latest T-MSIS data dictionary prior to generating each report and update definitions as needed.

204.4 Methodology

A) This report is organized into one section.

B) Data Sources:

1. The Health Plan will report member-level data from a number of sources. In addition to administrative records, GHP-specific sources for each metric are included in the MLDF.
2. If HP is providing more than 3 GHP supplemental services, please add additional columns in the same format.
3. For reference tables for aggregate and group data for reporting, as well as the data submission format for the submission of the member-level data file, refer to the "Reference Table and MLDF Data Submission Formats" in this report's subfolder in the "Report Reference Tables and Data Submission Formats" folder.
4. The MLDF shall be used to report GHP members during the reporting period and the GHP services they received.
5. The Self-Direction Payments tab shall be used to report the payments for self-directed services for GHP members.

C) Data Collection/Reporting:

1. Each report shall provide updates on all GHP activities the Health Plan has undertaken during the reporting period.

204.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. Percent of New and Existing GHP Members in Institutional Settings on the

last day of the reporting period

2. Percent of New and Existing GHP Members who transitioned off the waitlist at any point during the reporting period
3. Percent of Members who completed GHP who have been re-institutionalized
4. Percent of Members GHP Expenditures reported as encounters into HPMMIS

REPORT 205: HEALTH COORDINATION SERVICES

205.1 Introduction

- A) The purpose of this report is to monitor and track the health plan's provision of health coordination services to eligible members.
- B) This report should encompass all populations receiving HCS services.

205.2 Applicable Contract Sections

- A) Section 3.7 (Health Coordination Services) contains a description of Health Coordination Services (HCS) and the populations eligible for these services.
- B) Section 3.7.D contains the Health Plan's responsibilities for LTSS populations, including:
 - 1. Identification of Population
 - 2. Conducting screenings and assessments
 - 3. Developing Health Action Plans (HAPs)
 - 4. Implementing HAPs, and
 - 5. Reassessing members' needs
- C) Section 4.8 explains expectations for coverage provisions for LTSS eligible members, and subgroups within LTSS (At-Risk, NF LOC).
- D) Section 3.7.D contains the Health Plan's responsibilities for SHCN and EHCN populations.
- E) Section 6.2.E.2 (Covered Benefits and Services) includes the LTSS report, which is now the HCS report.
- F) Section 2.6 (Definitions/Acronyms) defines the SHCN and EHCN populations.
- G) Section 6.2.E.2 (Reports related to Covered Benefits and Services) provides information on the SHCN report, which is now the HCS report.

205.3 Terms and Definitions

A) **SHCN Terms**

1. **Number of enrolled members:** Total number of members enrolled in the Health Plan.
2. **Members** newly enrolled: Number of members newly enrolled in the Health Plan during the reporting quarter.
3. **Potentially eligible for SHCN/EHCN:** Any member the Health Plan identified by any method (i.e., new member welcome call, data analytics, referral, Health Plan quality improvement initiative, or other means) who may be eligible for SHCN/EHCN who has not yet gone through eligibility verification or been contacted for consent to participate.
4. **New SHCN/EHCN member:** Any SHCN or EHCN member who the Health Plan identified and confirmed eligible for SHCN or EHCN and who gave consent to participate within the reporting period.
5. **Existing SHCN/EHCN member:** Any SHCN/EHCN member who was identified, confirmed eligible, and gave consent to participate prior to the reporting period, who is still receiving SHCN/EHCN services during the reporting period.
6. **SHCN/EHCN members (New and Existing):** All members enrolled in SHCN/EHCN services that have been deemed eligible and consented to participate.

B) **HAP action items:** items that were discussed in the HAP that the care team would do for the Member to coordinate their care and implement the HAP between visits.

C) **Assessment:** the Health Plan's collection of health status, health conditions, social risk factors, and other information. This term is defined here due to variation in terminology in the past. The Assessment has been referred to as the Health and Functional Assessment (HFA) and the Functional Needs Assessment in the past.

D) **Health Action Plan (HAP):** a person-centered individualized plan that is based on an assessment and describes the medical, behavioral, and social needs of the members, and identifies all services to be utilized. This term is defined here due to variation in terminology in the past. The HAP has been

referred to as the Service Plan.

- E) **Expanded Health Care Needs (EHCN):** a member that has complex, costly health care needs and conditions, or whose risk of developing these conditions is imminent. The members that meet EHCN criteria are a subset of all SHCN members who are likely to substantially benefit from Health Coordination Services (HCS).
- F) **All Health Plan members:** Total number of members enrolled in the Health Plan.
 - 1. Please include members residing in institutional settings receiving institutional services.
- G) **Members newly enrolled in Health Plan:** Number of members newly enrolled in Health Plan during the reporting quarter.
- H) **LTSS members:** Members receiving LTSS, including those who receive "At-Risk" services and those who meet Nursing Facility Level of Care, and receive any types of HCBS or institutional services including nursing facility, waitlist, and subacute services.
- I) **Members Newly Entering LTSS and New LTSS Members:** Members who entered LTSS during the current reporting period, and who were not previously enrolled in LTSS. Members who were previously in LTSS but had a gap of 90 days or longer since their previous LTSS status was terminated may be considered "newly entering LTSS." The Health Plan shall also consider members already in LTSS but transitioning to the Health Plan from another Health Plan as "newly entering LTSS."
- J) **Existing LTSS members:** Members who were already enrolled in the Health Plan's LTSS program on the first day of the reporting period. A member is considered to be "enrolled" in LTSS if the Health Plan has received consent from the member to begin LTSS services.
- K) **At-Risk members:** Members enrolled in LTSS services, who do not meet criteria for nursing facility level of care (NF LOC) that have been deemed eligible and consented to participate. At-Risk members are eligible to receive a subset of pre-determined Home and Community Based Services (HCBS).
- L) **HCBS members:** Members enrolled in LTSS services who have been

deemed eligible for NF LOC that have opted to receive home and community-based services.

M) **Coordination Codes (C-Codes)**

1. The Coordination Codes (C-Codes) on the reference table must be used to convey the status of members receiving health coordination services. These codes are applicable to all populations receiving health coordination services, regardless of their inclusion in a special population (i.e. LTSS, SHCN, etc.).

N) **Transitional care:** is defined as transitional care management services provided to the member when the member transitions from an acute care setting (such as hospitals, skilled nursing facilities, etc.) back into the community.

O) **Service Categories:** These service categories are proposed for health plan activities only. Services performed by vendors will be reported as encounters, but may not be part of the new Health Care Coordination Report. Example lists are not meant to be exhaustive. Health plans may perform other services operationally that are not listed here, and MQD/PCG will help plans map these services to the final service categories.

Service Category	Definition	Activity Examples
Assessments	Conducting any assessments (HFA, 1147, SDOH, leveling assessments etc.)	<ul style="list-style-type: none"> • Conducting the HFA with a member either by face-to-face contact or telephonically. • DOES NOT include follow-up activities.
Care Planning	Development of Care Plan or Health Action Plan (HAP). Inclusive of updates. Not inclusive of follow-up activities.	<ul style="list-style-type: none"> • Developing the Health Action Plan with Member and Care Team. • Updating the Health Action Plan with the member and the member's Care Team • Could include monthly update calls.
Referrals and Care Management	Referrals/Care Management involves coordination with providers.	<ul style="list-style-type: none"> • Referral to HCBS, Foster Care, SHCN, EHCN, CCS, CIS+ • Coordination of Benefits • Referral for basic skills training • Sharing of HFA and HAP with providers • Coordinating with other members' providers • Coordinating with other members' HPs • Combined case reviews
In Home/Community Services	In-Home/Community Services occur when the member is being visited by health plan staff or in their residence for assistance with daily living tasks, coordination of social services (such as home modifications), or for activities related to following up after discharge.	<ul style="list-style-type: none"> • Provision of homemaker services or home care that are otherwise not covered by Medicaid • Meeting to check on understanding of discharge instructions/to make contact with social supports • Home Modifications - Installing an air conditioner, or shower support for members • Repair of Durable Medical Equipment.

Care Facilitation	Care facilitation is 1:1 ongoing facilitation to ensure that members receive services outlined in the care plan	<ul style="list-style-type: none"> • Medication Reminder Service • Monitoring or initiating delivery of medical supplies, Durable Medical Equipment • Appointment reminders and scheduling • Follow-up after hospitalization • Home Modifications - Installing an air conditioner, or shower support for members
Health Related Social Needs	Health Related Social Needs means activities that address non-clinical needs, specifically in the following domains, housing, transportation, and nutrition supports, and financial support.	<ul style="list-style-type: none"> • Referring members to medically tailored meal services or home delivered meals. • Providing non-emergency Medical Transport • CIS+ housing supports per month
Outreach	Outreach means initial and ongoing outreach to engage members in services or to conduct wellness checks or review member information. Outreach encounters can only be billed if they are conducted face-to-face or telephonically. Mass mailouts, mailings required for administrative functions, and contact through email are not considered valid encounters.	<ul style="list-style-type: none"> • Monthly Calls – wellness checks, basic touchpoints • Initial Outreach Call (i.e. pre-engagement) • Screening • LTFU/re-engagement • Change in address • Outreach attempts
Care Transitions	Care Transitions are activities that occur following a member hospitalization and possibly from other institutional settings such as NF/CCFFH or behavioral health crisis centers. Care transitions may include following up on a member's condition, or completing member forms to transfer members to a different level of care. It may also involve face-to-face visits in the hospital to ensure members understand discharge summaries.	<ul style="list-style-type: none"> • Post-discharge ER Visit • Care Setting Change facilitation, completing transfer forms. • Long term care placement • Foster care placement • Going home plus
Emergency/Disaster Support (Can be specified in CMS 1500 field 24C)	Emergency Supports are services provided to members to help prepare them for external events, such as natural disasters, or to shepherd them out of a crisis.	<ul style="list-style-type: none"> • Covid-19 outreach for vaccination and offer for additional support. • Disaster preparedness calls to alert a member to impending natural disaster. • Emergency referrals for members in mental health crises
Disease Prevention/Management	Disease Prevention/Management are activities promoting health and wellness of members. Disease management involves education and engagement of participants to make decisions to successfully promote their health, including proactive management of chronic conditions, prevention of other chronic conditions, and appropriate screening for emerging health problems.	<ul style="list-style-type: none"> • Nurse line Calls • Med Adherence calls • Follow-up with member following abnormal EPSDT Screening • Member Education

205.4 Methodology

A) This report contains an excel file organized into five tabs.

1. **Tab 1:** Member-Level File to include all members receiving health coordination services and their enrollment in special populations or programs such as LTSS, EHCN, GHP etc.
2. **Tab 2:** Services File to include services members are receiving during the reporting period.
3. **Tab 3:** Improper Payment Report
4. **Tab 4:** Health Action Plan (HAP)
5. **Tab 5:** Health Functional Assessment (HFA)
6. Please note, for tabs 4 and 5, health plans are expected to reports as much information as possible. However, MQD understands that the HAP and HFA may not be completed entirely and not all questions pertain to all members.
7. **Data Sources:** The Health Plan will report aggregate and member-level data from a number of sources. At this time, plans will report from internal administrative records in addition to HFA and HAP documentation conducted by the health plan or received from providers.
8. For reference tables for aggregate and group data for reporting, as well as the data submission format for the submission of the member-level data file, refer to the "Reference Files" Tabs in the reporting template. Please use the most recent HAP for any member receiving HCS during the quarter. So, if the member is receiving HCS during the quarter but their HFA or HAP was completed a year prior, please include that most recent information.

205.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. % New Members who completed their face-to-face initial assessment within 15 day of eligibility confirmation
2. % New and Existing Members whose HAP were shared with their PCP
3. % New and Existing Members transitioned off the waitlist at any point during the reporting period

4. % of members across HCBS members meeting NF LOC groups receiving authorized HCBS services
5. New members with completed new member welcome call/survey process to screen and identify eligibility
6. Initial HAPs completed within window (≤ 30 days from assessment)
7. Members overdue for re-assessments (≥ 12 months from last assessment)
8. Comprehensive updates to HAP completed within window (≤ 12 months from last update)
9. SHCN members receiving ≥ 1 Health Coordination Service per quarter
10. EHCN members receiving ≥ 1 Health Coordination Service per month

REPORT 206: COMMUNITY INTEGRATION SERVICES PLUS MEDICAL RESPITE

206.1 Introduction

- A) The purpose of this report is to monitor the Health Plan's provision of Community Integration Services Plus (CIS+) Medical Respite Services. The data gathered will be used to assess quality of services provided, contract compliance, and evaluation of outcomes associated with engagement.

206.2 Applicable Contract Sections

- A) Memo QI-2601 and any future amendments/replacements
- B) Section 6.2.E.2 notifies the Health Plan about DHS reporting requirements for CIS+.

206.3 Terms and Definitions

- A) **Episode:** A single episode is comprised of a pre-procedural stay, post-procedural stay, short-term recuperative care, or short-term post-hospitalization stay all resulting in a discharge. An episode can also be defined as a member found to be ineligible or who declined to receive services. If a member subsequently is found to be eligible for medical respite after completing a medical respite episode, then the member enters a separate medical respite episode.
 - 1. For members who have both a pre-procedural and post-procedural stay following the same procedure, these will be logged as two separate episodes. Eligibility, authorization, consent, and PCSP information shall be copied for both episodes.
- B) **Episode Begin:** An episode for a member begins when a completed medical respite authorization form is received by a Health Plan. Both denied and authorized medical respite stays constitute an episode.
- C) **Episode End:** An episode for a member ends when: 1) the health plan finds the member ineligible or cannot confirm eligibility for medical respite; 2) the member does not consent to receive medical respite services; or 3) the member is discharged from medical respite. Note that a discharge form must be completed twice for members who complete a pre-procedural and post-

procedural medical respite stay for the same procedure.

- D) **Episode-level Data File (ELDF):** Unlike member-level data files (MLDFs), Health Plans will report each medical respite episode as separate rows in the ELDF. Only episodes that were open at any point during the reporting quarter should be included. Similarly, all discharges should only be reported in the reporting quarter when the member was discharged. It is possible that a member may have multiple episodes in a quarter; thus, the member may have multiple rows in the ELDF. Also, if a member has an open episode as of the last day of the reporting period that episode should be carried over into subsequent quarters until the episode ends.
- E) **Discharge:** A member is discharged from medical respite when they: 1) no longer need services; 2) leave against medical advice (AMA); 3) no longer qualify for Medicaid; 4) are deceased; 5) max out on benefit; or 6) require re-institutionalization such as a nursing facility or hospitalization.
1. A member who completes both pre-procedural and post-procedural medical respite for the same procedure shall have discharge planning provided twice.
- F) **Transfer:** Health Plans that had a member either transfer out (to another Health Plan) or received a transfer (from another Health Plan) should note per the data format instructions. A transfer is not defined as an internal transfer (e.g. HEALTHPLAN to XHEALTHPLAN).

206.4 Methodology

A) This report is organized into two sections.

1. In Section 1, the Health Plan shall provide a data file, "episode-level data file, ELDF" that will contain data on member demographics, referral and authorization, PCSP, service utilization, and discharge information.
2. In Section 2, the Health Plan shall provide the CIS+ Medical Respite Qualitative Data Collection Component (QDCC).

B) Section 1: Integrated Episode-level Data File

1. Data Sources:

- a. The Health Plan will report data from several sources. In addition to the Health Plan's administrative records, report-specific sources include:
 - 1) Medical Respite Authorization Form
 - 2) CIS+ Consent Form
 - 3) Person-Centered Services Plan (PCSP)
 - v Medical Respite PCSP
 - vi CIS+ Action Plan
 - vii Health and Functional Assessment/Health Action Plan (HFA/HAP)
 - 4) Claims
 - 5) Medical Respite Discharge Form
- b. While Health Plans can leverage one of three PCSP options to guide person-centered planning while in medical respite, the following shall guide how Health Plans will report specific data:
 - 1) Medical Respite PCSP
 - viii Reported in Medical Respite Report
 - 2) CIS+ Action Plan
 - i Reported in CIS+ HNS/HS Report (only once starting to receive HNS/HS)
 - 3) HFA/HAP
 - i Reported in Health Coordination Services (HCS) Report
- c. For members who complete both pre-procedural and post-procedural medical respite for the same procedure, Health Plans will only need to complete the authorization, eligibility determination, consent, and PCSP once at the pre-procedural medical respite stay. This information should be copied for both episodes. However, a discharge form must be completed for both pre- and post-procedural housing.

C) Other Information:

1. If a member received CIS+ housing navigation supports and medical respite during the same quarter, then they should be reported both in the CIS+ Medical Respite report and CIS+ Housing Navigation Supports/Housing Supports report.
2. Fields that are not yet applicable, such as discharge information, should not be left blank but rather completed per data format instructions.

D) In **Section 2**, the Health Plan shall provide descriptive details about the Health Plan's medical respite implementation and challenges during the reporting period. These qualitative questions may be found in the report template document.

206.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance:

1. Percent of eligibility screens conducted within 7 days of receipt of the Medical Respite Authorization form
2. Percent of episodes where member met both clinical and housing eligibility
3. Percent of episodes where PCSP was conducted within three days of medical respite admission
4. Percent of episodes where member was referred to health coordination services (amongst members previously unengaged)
5. Percent of episodes where member was discharged to sheltered location
6. Percent of episodes where member was discharged to unknown location
7. Percent of potentially eligible episodes authorized for services
8. Percent of episodes where member consented for services and received services during the quarter
9. Percent of episodes where member consented to and received both medical respite and housing navigation supports services

REPORT 301: INTERPRETATION/TRANSLATED DOCUMENTS

301.1 Introduction

- A) The purpose of this report is to monitor the Health Plan's compliance with the requirement to provide language interpretations and translations of documents into other languages to members with Limited English Proficiency (LEP).

301.2 Applicable Contract Sections

- A) Section 9.4.C, Language and Format Requirements for Written Materials.
- B) Section 9.4.D, Interpretation Services
- C) Section 6.2.E.3 that describes the reports related to Member Services.

301.3 Terms and Definitions

- A) **2017 Public Use Microdata Sample (PUMS) Code:** American Community Survey (ACS) PUMS Language Code List developed in 2017. The list in this report is modified slightly to add a dummy code for American Sign Language, to enable capturing the provision of services to persons with hearing impairments.
- B) **2018 Language Microdata Code:** ACS Code assigned to each ISO 639-3 language, referred to in this report as "Detailed Language". One or more detailed languages may group up to a single PUMS Code and "Language."
- C) **ISO 639-3 Code:** Maintained by SIL International, ISO 639-3 is a set of codes that defines three-letter identifiers for all known human languages.

301.4 Methodology

- A) **This report is organized into one section.**
- B) **Section 1 provides a member-level data file (MLDF).**
 - 1. Health Plans shall collect and maintain data on all language translations and interpretations provided, including for American Sign Language.
 - 2. To prepare the report, languages the Health Plan has provided

interpretation or translation services in shall be mapped to "DHS Language Group." Please refer to the "Language Ref" tab of "Language Reference and Submission Form" in this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder. The "DHS Language Group" parses twenty-five(25) distinct languages and groups all other languages into a twenty sixth category.

3. The format of the MLDF is provided in the "Language Reference and Submission Format" document.
4. General variables in the dataset that are not particular to this report are to be reported as defined by the "Health Plan Provider Network (HPS) File" in the HPMMIS Health Plan Provider Technical Guide.
5. Data shall be reported at the level of each individual interpretation or translation service provided to a member and shall represent the disaggregated version of the aggregate metrics provided in Section 1.
6. For "Medicaid ID" list the Med-QUEST Assigned Member Identification Number.
7. For "SVC_REQUEST_DATE", list the date the service was requested. If a request for services is placed in advance of the date the service is needed, then the date of the requested services is the date when the services are needed.
8. For "SVC_FULFILLED_DATE", enter the date when the health plan fulfilled the service request (not the appointment date). Date health plan secured interpreter or translator for the member.
9. The "Type of Service Requested" shall be either an interpretation ("I") or translation ("T").
10. The "Number of Services Requested" shall represent either the number of services requested on or for a given date. For example, the member may request the translation of multiple documents, or may request interpretation services at multiple medical appointments scheduled on the same date.
11. If multiple services were requested on the same date, but fulfilled on different dates, then they must be listed on separate lines. Services may

only be grouped in a single line if they were the same type, required the same language, were requested on the same date and fulfilled on the same date.

12. Use the "Language Ref" tab to crosswalk the Language Code (2017 PUMS Code) corresponding to the language into which translation or interpretation services were requested.
13. Use the "Language Ref" tab to crosswalk the Language Detailed Code (2018 Language Microdata Code) corresponding to the language into which translation or interpretation services were requested.
14. Use the "Language Ref" tab to map the "DHS Language Group" corresponding to the language into which translation or interpretation services were requested.
15. Notate whether service was provided using a "Y" or "N" in the "Service Provided" field.
16. List the "Service Provided Date"; if the service was not provided then leave blank
17. List who provided services in the "Service Provided By" field. Services may be provided by bilingual health plan staff ("ST"), community volunteers ("CV"), agencies contracted by the Health Plan ("HC"), individual parties contracted by the Health Plan ("OC"), or as applicable, others ("OT") who do not fit into the above categories.
18. "Service Location" identifies whether the service was provided in person ("IP"), by telephone ("TP") or in writing ("WR"). In person services include face-to-face telehealth sessions.
19. Describe the "Service Not Provided Reason". If the Health Plan is in the process of fulfilling the request, please note. These types of requests shall be reported in the following quarter.
20. If the Health Plan continues to search for an appropriate service provider, or is no longer attempting to fulfill the request, please note under "Service Not Provided Resolution."

301.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance on the Interpretations and Translated Documents Report.

1. Percent of Interpretation Requests Fulfilled (All Languages)
2. Percent of Translation Requests Fulfilled (All Languages)

REPORT 303: CALL CENTER REPORT

303.1 Introduction

- A) The purpose of this report is to monitor and assess the quality of call center services provided by the Health Plan.

303.2 Applicable Contract Sections

- A) Section 9.4.I Member Toll-Free Call Center, including member call center and nurse line.
- B) Section 6.2.E.3. Report Descriptions (Member Services) and 42 CFR §438.66(c).
- C) Section 8.4.D Provider Call-Center/Prior Authorization Line.

303.3 Terms and Definitions

- A) **Number of Attempts:** The total number of calls made to the call center within the reporting period. This includes calls both answered and unanswered by the call center system.
- B) **All Trunks Busy (ATB):** The number of calls where the caller receives a busy signal while trying to reach the call center because every trunk into the call center is unable to accept incoming calls due to being occupied by other callers or being non-operational.
- C) **Number of Failed Attempts:** This represents the number of calls unable to reach the call center. Any call intentionally blocked by the call center or otherwise unsuccessful due to technical issues within the call center system is considered a failed attempt. The number of failed attempts includes calls failed due to ATB and any other reasons.
- D) **Calls Delivered to the Customer Service Representative (CSR) Queue:** Total number of calls delivered into the CSR queue.
- E) **Calls Abandoned While in the CSR Queue:** The number of calls delivered to the CSR Queue where callers abandon the call prior to connecting with a CSR.

- F) **Calls Successfully Delivered to a CSR:** The difference between the total number of calls delivered to the CSR Queue and those abandoned while in the CSR Queue.
- G) **Hold Time:** The amount of time in minutes callers who are placed in queue to speak to a customer service representative spend in queue prior to the call being answered. This includes ringing, delay recorders, music and time spent navigating option menus. The time begins when the caller enters the CSR queue and ends when the caller is connected to a live voice. Calls that were abandoned before being connected to a CSR should not be counted. If the caller is offered a call back option, this includes the time spent by the caller on the phone while providing their callback information and also any wait time occurring during the call back before the caller is connected to a customer service representative.
- H) **Call Center Sign-In Hours:** The Health Plan shall add up all sign in hours for all CSRs working in the quarter. The measure shall not include supervisors, support staff, etc., unless they periodically answer calls, at which point the amount of time they spent answering calls are logged into the system and included in the total call center sign-in hours. Sign-in hours shall exclude non-work time such as lunch breaks, but shall include work time such as training and other non-telephone inquiry work load.
- I) **Average FTE Theoretically Available for Answering Calls:** The number of full-time equivalents (FTE) theoretically available to the call center for answering calls, obtained by multiplying the total "Call Center Sign-In Hours" by 0.8125 and dividing by the maximum number of working hours available in the quarter. This number will be auto-calculated in the ALDF, and does not need to be inputted.
- J) **Expected Number of Calls Handled in the Quarter:** The "Average FTE Theoretically Available for Answering Calls" multiplied by an expected benchmark of 1000 calls per FTE per month multiplied by three months. This number will be auto-calculated in the ALDF, and does not need to be inputted.
- K) **CSR Active Call Center Response Time in Hours:** Total amount of time when CSRs were plugged in, logged in, handling calls, making outgoing calls, or in the after-call work state (i.e. performing necessary actions and documentation after a call is completed). This metric should not include

breaks, lunch, training, and when performing any other non-telephone inquiry workload.

- L) **Total Number of Working Days in the Quarter; Total Number of Call Center Working Hours in Quarter:** The total number of days the call center operated in the quarter; and total number of hours during the quarter when the call center was open.
- M) **Total Calls Answered by a CSR that were Resolved Without Callback:** The number of calls delivered to the CSR Queue and answered that were resolved without the need for callback.
- N) **Callback Resolution Days:** Calls not resolved by the CSR during the first call due to a need for further information, contact with another CSR, etc., may necessitate a callback to the caller from the CSR or someone else in the call center in order to resolve the inquiry. This measure is the total number of business days taken for resolution of calls requiring callback. This information shall be used to determine the "Calls requiring Callbacks Resolved within Five (5) Business Days."

303.4 Methodology

- A) **This report has one section:**
- B) In **Section I: Call Center Metrics**, the Health Plan shall report the call center metrics outlined for the Health Plan's member call center, and 24-hour nurse line, and provider call center. The metrics used to populate each data field of the file shall follow the definitions provided in the above report Terms and Definitions.
 - 1. The Health Plan shall gather information from its call centers' premise-based equipment and call center sign-in information to complete this report.
 - 2. For statistics pertaining to the nurse line, all references to "customer service representative" shall be interpreted to be the nurse on duty who is answering the call.
 - 3. The Health Plan shall describe its call center operations as accurately as possible, including staff leveraged from other programs or lines of business to the extent that only their actual time performing call center

activities are used for this report.

303.5 Key Performance Indicators (KPIs)

A) DHS shall rate the Health Plan's performance using the following KPIs.

1. Blocked Call Rate: Number of failed attempts per one hundred (100) call attempts in each quarter.
2. Call Abandonment Rate: The number of calls abandoned prior to connecting with a customer service representative divided by the total number of calls delivered into the customer service representative queue per one hundred (100) calls delivered to the CSR Queue.
3. Percent of Calls Meeting Hold Time Standard: The percentage of calls whose hold time is less than or equal to 30 seconds.
4. Average Speed of Answer: The average amount of time that all calls waited in queue before being connected to a live voice customer service representative. This measure is an aggregate statistic of the Hold Time measure.
5. Excessive Hold Time Threshold: This measure is calculated as the average hold time (i.e. the Average Speed of Answer) plus two standard deviations to provide the hold time threshold for callers with the longest hold times (i.e. callers in the top ~4%).
6. Percent of Callbacks Resolved in a Timely Manner: Percentage of Calls requiring Callbacks that were Resolved within Five (5) Business Days.

REPORT 304: MEMBER GRIEVANCE AND APPEALS

304.1 Introduction

- A) The purpose of this report is to monitor and assess the quality of Health Plan's system and responsiveness to address member grievances and appeals.

304.2 Applicable Contract Sections

- A) Section 6.2.E.3.a.1 (Member Grievances and Appeals Report) describes per 42 CFR §438.66(c), the grievance and appeals information that is required to be submitted to DHS in compliance with 42 CFR§438 Subpart F.
- B) Section B describes the grievance and appeal recordkeeping required per 42 CFR §438.3(u).

304.3 Terms and Definitions

A) Grievances and Appeals Service Categories:

1. General outpatient services
2. General Inpatient Services
3. Inpatient behavioral health services
4. Outpatient behavioral health services
5. Covered Outpatient Prescription Drugs and Pharmacy and Prescription Drugs
6. Skilled Nursing Facility (SNF) Services
7. LTSS
8. Non-emergency Medical Transportation (NEMT)
9. Other Service Types
10. Durable Medical Equipment (DME) and Supplies
11. Home Health/Hospice

12. Emergency Services/Emergency Department

13. Therapies (Physical)

14. Dental Services (Emergent Only)

15. Therapies (Mental)

304.4 Methodology

A) This report is organized into two sections:

1. Section I: Member-level and summary data on grievances
2. Section II: Member-level and summary data on appeals

B) In **Section I: Grievances**, the Health Plan shall complete all data fields in the embedded excel file in the report template by referring to "Grievances Data Format MLDF" in this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder. The Health Plan shall use one of the provided codes to describe the type of grievance. If the grievance does not fit one of the codes, the Health Plan shall use -999 and provide an explanation in the next column. If the same grievance reports multiple issues, then list the grievance only once (i.e. one row) and report all applicable grievance codes. If there is a grievance for multiple codes, then they should be reported individually in separate columns. For additional information, please see Managed Care Program Annual Report (MCPAR) Technical Guidance, Topic: Appeals and Grievances:
<https://www.medicaid.gov/medicaid/managed-care/downloads/mcpar-appeals-grievances-tech-guidance.pdf>

C) In **Section II: Appeals**, the Health Plan shall complete all fields in the embedded excel file in the report by referring to "Appeals Data Format MLDF" in this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder.

1. The Health Plan shall use one of the provided codes to describe the type of appeal. If the same appeal reports multiple issues then list the appeal only once (i.e., one row) and report all applicable appeal codes in column B.

304.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. Percent of Grievances with Written Notice of Acknowledgement Sent Within 5 Business Days
2. Percent of Grievances with Notice of Decision within 30 days (without approved extension)
3. Percent of Appeals with Written Notice of Acknowledgement Sent Within 5 business Days
4. Percent of Appeals with Notice of Decision Sent within 30 Days (without approved extension)
5. Percent of Expedited Appeals with Notice of Decision within 72 hours (without approved extension)
6. Percent of grievances resolved in favor of member
7. Percent of appeals resolved in favor of member

REPORT 401: PROVIDER GRIEVANCES AND CLAIMS

401.1 Introduction

- A) The Health Plans shall provide DHS a quarterly report on any provider grievances received during the reporting period, as well as metrics on the timely payment of claims.

401.2 Applicable Contract Sections

- A) Section 8.4 Provider Services describes the Provider Grievance and Appeals Process, noting that the Health Plan shall log all provider grievances and report to DHS.
- B) Section 6.2 Report Descriptions describes the Provider Grievances and Claims Report, citing 42 CFR §438.66(c) as the regulation Health Plans shall follow to submit provider grievances and appeals. This section also cites 42 CFR §447.46 – Timely claims payment by Health Plans as the regulation guiding the Health Plan’s reporting of timely claims payment.

401.3 Terms and Definitions

- A) **Provider Grievance:** An expression of dissatisfaction made by a provider about issues, including, but not limited to:
 - 1. Benefits and limits;
 - 2. Eligibility and enrollment;
 - 3. Member issues, including:
 - 4. Members who fail to meet appointments or who do not call for cancellations;
 - 5. Instances in which the interaction with the Member is not satisfactory;
 - 6. Instances in which the Member is rude or unfriendly;
 - 7. Other Member-related concerns.
 - 8. Health Plan issues, including difficulty contacting the Health Plan or its Subcontractors due to long wait times, busy lines, etc.; problems with the

Health Plan's staff behavior; delays in claims payment; denial of claims; claims not paid correctly; or other Health Plan issues;

9. Issues related to availability of health services from the Health Plan to a Member, for example delays in obtaining or inability to obtain emergent/urgent services, medications, specialty care, ancillary services such as transportation, medical supplies, etc.
10. Issues related to the delivery of health services, for example, the PCP was unable to make a referral to a specialist, medical was not provided by a pharmacy, the Member did not receive services the Provider believed were needed, the Provider is unable to treat Member appropriately because the Member is verbally abusive or threatens physical behavior; and
11. Issues related to the quality of service, for example, the provider reports that another provider did not appropriately evaluate, diagnose, prescribe or treat the Member, the provider reports that another provider has issues with cleanliness of office, instruments, or other aseptic technique was used, the provider reports that another provider did not render services or items which the Member needed, or the provider reports that the Health Plan's specialty network cannot provide adequate care for a Member.

- B) **Claim:** Per CFR §447.45, claim means (1) a bill for services, (2) a line item of service, or (3) all services for one member within a bill. This report excludes "zero" paid claims where no Medicaid liability was determined due to payment in full by other insurance.
- C) **Date of Receipt:** The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim.
- D) **New Claims Submitted for Processing:** Number of new claims the Health Plan received during the current reporting period.
- E) **Claims not Processed from Previous Quarter:** Number of claims the Health Plan received prior to the current reporting period that were not processed previously.
- F) **Total Claims for Processing:** Sum of New Claims Submitted for

Processing, Claims Not Processed from Previous Quarter, and New Claims Received in the Previous Quarter

- G) **Claims Processed:** The total number of claims the Health Plan either paid or denied during the reporting period.
- H) **Claims to be Processed:** The total number of claims the Health Plan did not pay or deny during the reporting period that will be paid or denied in a future reporting period.
- I) **Claims Paid:** The total number of claims the Health Plan paid during the reporting period.
- J) **Claims Denied:** The total number of claims the Health Plan denied during the reporting period.
- K) **Duplicate claim:** Any claim denied because it is a duplicate of a claim that is in process or has already been processed.
- L) **Claims Processed at 30 days after date of claims receipt:** The total number of claims either paid or denied within 30 days of the Health Plan date of receipt.
- M) **Claims Processed at 90 days after date of claims receipt:** The total number of claims either paid or denied within 90 days of the date of receipt.
- N) **Claims Denial Reasons:**
 - 1. **Not Meeting PA/Referral Requirements:** a healthcare provider does not adhere to the established guidelines or criteria for making referrals
 - 2. **Late Submission:** a healthcare provider submits a claim, documentation, or request for reimbursement to an insurance company or payer after the deadline established by the payer's policies
 - 3. **Provider Ineligible on Date of Service:** a claim is denied because the healthcare provider was not considered eligible or credentialed with the insurance payer on the specific date when the healthcare service was provided
 - 4. **Member Ineligible on Date of Service:** a claim is denied because the patient (referred to as the "member") was not eligible for coverage under

their health insurance plan on the specific date when the healthcare service was provided

5. **Member TPL Was Not Billed First:** the provider is facing a denial or issue with a claim because the member's "Third-Party Liability" (TPL) insurance was not billed before billing the primary health insurance
6. **Billing Error:** a mistake or inaccuracy in the way a healthcare service, procedure, or treatment was billed to an insurance company or patient
7. **Additional Information Needed:** a claim is delayed or denied because the insurance company or payer requires more documentation or details to process the claim accurately
8. **Duplicated Claims (bundled service or single service):** the provider has submitted multiple claims for the same service, procedure, or treatment provided to a patient on the same date
9. **Not Member Responsibility (e.g. General Excise Tax (GET)):** provider is challenging a claim denial because the costs in question should not be the financial responsibility of the patient
10. **Other**

O) **Specific Providers:**

1. **Hospital Inpatient:** services recorded on Bill Type 11X, 12X, 18X, 21X, 28X, 41X, or 86X and Billing Provider Type is 02 (Hospital)
2. **Hospital Outpatient (including Emergency Department):** services recorded on Bill Type 13X, 14X, 32X, 33X, 34X, 43X, 71X, 72X, 73X, 74X, 75X, 76X, 77X, 79X, 83X, 84X, 85X, or 89X and Billing Provider Type is 02 (Hospital)
3. **Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC):** services where Provider Type is C2 (FQHC) or 29 (Community/Rural Health Center)
4. **Nursing Home:** services recorded on Bill Type 21X, 22X, 23X, 28X, 61X, 63X, 65X, 66X
5. **Community Care Foster Family Homes (CCFFH):** services where

Billing Provider Type is 50 (Adult Foster Care)

6. **Hospice:** services record on Bill Type 81X or 82X
7. **Home Health Agencies:** services where Billing Provider Type is 23 (Home Health Agency)

401.4 Methodology

- A) **This report is organized into three sections.**
- B) In **Section 1: Provider Grievances**, the Health Plan will use the Excel template to list all provider grievances received or open during the reporting period. The Health Plan shall refer to the Data Format file for additional information on the fields required for reporting. If the Health Plan receives a provider grievance during a quarter but it is not resolved until the following quarter, the Health Plan shall list the grievance on the PGC report during which the Health Plans received the grievance, and will list the grievance in each PGC report until the grievance is resolved. In some situations, a provider grievance case may be closed but not resolved. The Health Plans shall report this grievances for each reporting period they are open until the case is closed.
- C) In **Section 2: Claims Processing and Payment (Excluding Specific Providers in Section III)**, the Health Plan will use the embedded Excel file to provide a tabulation of claim lines received and/or processed during the reporting period.
 1. In the Section 2 tabulation the Health Plan will exclude all claims by Specific Providers captured in the tabulation in Section 3.
 2. The Health Plan shall provide a count of claims, as opposed to claim lines, for rows 2 through 9.
 3. Denial reasons shall be tabulated at the claim line level.
 4. The tabulation will calculate the percentage of claims processed within 30 and 90 days of date of receipt.
 5. The Health Plan shall provide a list of the top 3 "Other" reasons the Health Plan denied claims and will provide a count of claims denied for

those reasons.

D) In **Section 3: Claims Processing and Payment (Specific Providers)**, the Health Plan will use the embedded Excel file to provide a tabulation of claims received and/or processed during the reporting period.

1. In the Section 3 tabulation the Health Plan will only include claims from Specific Providers.
2. The Health Plan shall provide a count of claims, as opposed to claim lines, for rows 2 through 9.
3. Denial reasons shall be tabulated at the claim line level.
4. The tabulation will calculate the percentage of claims processed within 30 and 90 days of date of receipt.

401.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. The Health Plan has a process in place to receive and monitor provider grievances
2. Percent of claims (excluding Specific Providers) Processed at 30 Days after claims receipt
3. Percent of claims (excluding Specific Providers) Processed at 90 Days after claims receipt
4. Percent of Hospital Inpatient claims Processed at 30 Days after claims receipt
5. Percent of Hospital Inpatient Processed at 90 Days after claims receipt
6. Percent of Hospital Outpatient claims Processed at 30 Days after claims receipt
7. Percent of Hospital Outpatient claims Processed at 90 Days after claims receipt
8. Percent of FQHC/RHC claims Processed at 30 Days after claims receipt

9. Percent of FQHC/RHC claims Processed at 90 Days after claims receipt
10. Percent of Nursing Home claims Processed at 30 Days after claims receipt
11. Percent of Nursing Home claims Processed at 90 Days after claims receipt
12. Percent of CCFFH claims Processed at 30 Days after claims receipt
13. Percent of CCFFH claims Processed at 90 Days after claims receipt
14. Percent of Hospice claims Processed at 30 Days after claims receipt
15. Percent of Hospice claims Processed at 90 Days after claims receipt
16. Percent of Home Health Agency claims Processed at 30 Days after claims receipt
17. Percent of Home Health Agency claims Processed at 90 Days after claims receipt

REPORT 402: VALUE DRIVEN HEALTHCARE

402.1 Introduction

- A) The purpose of this report is to track the Health Plan's progress towards implementing and enhancing value-based purchasing (VBP) using the Health Care Payment Learning & Action Network (HCP LAN) Alternative Payment Model (APM) framework.

402.2 Applicable Contract Sections

- A) Section 7.2.D (Value-Based Payment) contains information about VBP and the APM framework.
- B) Section 6.2.1 (Provider Network/Services) notifies the Health Plan about reporting requirements related to VBP.

402.3 Terms and Definitions

A) APM Definitions

Payment Category	Definition	Examples (List not exhaustive)
1 Fee-for-service	No link to quality or value	All contracts and/or payment arrangements that are exclusively fee for service
2A Foundational Payments for Infrastructure & Operations	Foundational spending to improve care, e.g., care coordination payments, and infrastructure payments.	Care coordination fees and payments for HIT investments
2B Pay for Reporting	Payments for reporting on performance measures.	Bonuses for reporting data or penalties for not reporting data
2C Rewards/ Penalties for Performance	Pay-for-performance (P4P) rewards to improve care, such as provider performance to population-based targets for quality such as a target HEDIS rate; may also include Pay-for-performance (P4P) penalties where providers miss target rates on select performance measures.	Bonuses for quality; penalties for lower quality or missed benchmarks
3A Shared Savings	Providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets if quality targets are met. Cost target may be for a comprehensive set of services (total cost of care) or for a limited episode/bundle.	Savings shared with contracted entity

3B Shared Risk	Providers have the opportunity to share in a greater portion of the savings that they generate against a cost target or by meeting utilization targets if more quality targets are met. Additionally, payers recoup from providers a portion of the losses that result when cost or utilization targets are not met.	Episode-based payments for procedures and comprehensive payments with upside and downside risk
3N Risk-based Payments Not Linked to Quality	Category 3 APMs with shared savings or shared risk components, where the savings and risks are not tied to quality-based targets.	Shared savings/risk models without performance accountability
4A Partial Capitation or Episode-Based Payment	Providers receive prospective-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a defined scope of practice (e.g., partial capitation or episode).	Capitation payments for specialty services
4B Comprehensive Population-Based Payment	Providers receive prospective population-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care for a comprehensive set of services that covers all of an individual's health care.	Global budgets with performance accountability
4C Integrated Finance and Delivery System	Payments to a highly integrated finance and delivery system.	Global budgets within integrated systems with performance accountability
4N Capitated Payments Not Linked to Quality	Category 4 APMs that use prospective, population-based payments without a quality component.	Global budgets without performance accountability

- B) Billing Provider Type:** For the purpose of this report, the provider refers to the billing provider or entity, categorized by site or specialty: Primary Care, Federally Qualified Health Center (FQHC)/Community Health Center (CHC)/Rural Health Center (RHC), Hospital, Behavioral Health, Specialist, Long-term Service & Supports (LTSS) Providers, or Other.
- C)** For reference tables relevant to this report refer to "Reference Tables and Data Submission Formats.xlsx" in this report's subfolder within the "Report Reference Tables and Submission Formats" folder.
1. The tab "APM Category Ref" identifies the allowed values for the variable "APM_CAT" which appears in both the PLDF and MAT.

2. The tab titled "VBP Provider Type Ref" provides a reference table that crosswalks Med-QUEST Provider Types and VBP Category.
3. The tab titled "Physician Organization Ref" provides a reference table with a list of Physician Organizations in Hawaii.
4. The tab titled "VBP Provider Specialty Ref" provides a reference table that crosswalks Provider Specialty Types and VBP Category.
5. The variable "Provider VBP Category" appears in both the PLDF and MAT. To assign the appropriate VBP Category, the Health Plan shall do the following:
 - a. First, the Health Plan shall map all possible Med-QUEST Provider Types in the "VBP Provider Type Ref" to the corresponding VBP Category.
 - b. Where the billing provider type maps to a generic VBP Provider Type (e.g., Provider Type 01) without an assigned VBP Provider Type, the Health Plan shall assign the provider to the most appropriate VBP Provider Type(s) for the purposes of this report.
 - 1) If a given provider has multiple distinct VBP Provider Types because they perform different types of services (e.g. a single provider serving as a primary care clinic and a hospital), the provider must be assigned to each VBP Provider Type and payment arrangements under these different provider types must be parsed.
 - c. After the initial mapping, VBP Category may remain null for some providers; for these providers alone, the Health Plan shall use the "VBP Provider Specialty Ref" tab for mapping to VBP Category.
 - d. Health Plans that engage in integrated finance and delivery systems shall report Total Cost of Care for All Providers and TOTAL COST OF CARE for their 4C arrangement in rows 79, 108, and 116. Health Plans who do not engage in integrated finance and delivery systems will report in these rows.

D) **Physician Organization:** A Physician Organization provides managed care support for physicians often in the form of foundational business aspects,

patient care coordination, collective accountability, and quality improvement initiatives. Physician Organizations can range from independent physician organizations for providers in private practice, to large accountable care organizations.

402.4 Methodology

A) This report is organized into four sections.

1. In Section 1, the Health Plan shall provide descriptive details about all payment initiatives during the reporting period in the Initiative Inventory Data File (IIDF);
2. In Section 2, the Health Plan shall provide aggregate metrics on reimbursement by APM Category in the Aggregate-Level Data File (ALDF);
3. In Section 3, the Health Plan shall include a Provider-Level Data File (PLDF); and
4. In Section 4, the Health Plan shall include a Member Attribution Table (MAT).

B) The Health Plan shall report on all payment initiatives, including VBP and non-VBP arrangements that it has implemented with various providers and provider groups. All payment initiatives shall be named and identified in Section 1 IIDF. Every provider who the Health Plan pays to serve its Medicaid members shall be assigned to at least one payment initiative and may be assigned to more than one payment initiative.

C) Member Attribution must be conducted on a quarterly basis. Within an annual report, a member must not be attributed to a new provider more than once every 3 months.

D) The report shall include all arrangements that were active at any time during the reporting period.

E) Anchor and run-out dates used for all calculations shall match the Health Plan's MLR Report for the same reporting period.

F) The Health Plan's report shall exclude payments related to MQD's Hospital

Pay for Performance Program or Nursing Facility Program that are administered by MQD via a directed payment arrangement.

G) **Section 1: Initiative Inventory Data File (IIDF):** In the embedded Excel document named Initiative Inventory Data File (IIDF), the Health Plan shall enter descriptive data into all applicable cells.

1. The purpose of the IIDF is to help inventory, identify, and understand which category the Health Plan payment initiative would be classified under the Health Care Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework while clarifying the organizational structure and architecture in which the payment model operates.
2. The Health Plan shall inventory and identify every specific payment initiative to health care providers (i.e. health professionals or institutional providers) and other stakeholders, including value-based payment initiatives as defined by the LAN framework as well as initiatives that are not deemed value-based payment initiatives. All initiatives (i.e. all types of payment arrangements the Health Plan has with providers) shall be identified.
3. The Health Plan shall identify every payment initiative it had in place over the reporting period, including initiatives which are no longer operational, initiatives implemented only during a public health emergency, and initiatives even if payments have yet to be made. If there are five specific payment initiatives, the Health Plan shall report five rows. There is no limit to the number of payment initiatives that the Health Plan may identify, but the Health Plan shall identify every distinct payment initiative in its own row.
 - a. Initiatives may correspond with distinct contract types that the Health Plans have with providers.
 - b. If an initiative is administratively grouped but is best described as two or more distinct sub-initiatives, the Health Plan may, at its discretion, report these as separate initiatives.
 - c. Any non-capitated purely FFS Initiative with no VBP components may just be identified generically under the initiative name "FFS;"

however, if there are different features under different types of FFS arrangements that would be helpful to parse (e.g., providers contracted under the Medicaid Line of Business vs. non-participating providers), the Health Plan is asked to differentiate its various non-capitated FFS Initiatives as needed.

4. Each initiative shall be numbered (field 0 in IIDF) and shall be named by the Health Plan (field 1 in IIDF).
 - a. For “Initiative Number”, the Health Plan shall enumerate each distinct payment initiative.
 - b. For “Name of Initiative”, the Health Plan shall provide the name of the specific payment initiative. This field shall correspond to all subsequent references of the “Named Initiative”.
 - c. For “VBP Provider Types,” the Health Plan shall list the VBP Provider Type(s) to which this initiative applies (Primary Care, FQHC/CHC/RHC, Hospital, Behavioral Health, Specialist, LTSS Providers, and/or Other). A given initiative may apply to any number of VBP Provider Types.
 - d. For “Summary”, the Health Plan shall provide a brief summary of the purpose and intent of this specific Named Initiative in 150 words or less.
 - e. For “Payment Methodology”, the Health Plan shall provide a description of this Named Initiative’s payment methodology including patient attribution, provider attribution, description of formula or algorithm, quality measures, and other information used to determine payment levels including any distinctions in the payments between health professional and institutional providers. Quality measures may be defined in any way, and not necessarily be restricted to HEDIS measures. The Health Plan shall describe for this specific payment initiative how payments are allotted and whether incentives reach individual providers or another organization. The Health Plan shall describe any and all internal attribution methodologies used under this Named Initiative.
 - f. For “Quality Measures”, the Health Plan shall describe if and how quality metrics in this Named Initiative align to the Health Plan

reports to MQD and the Medicaid Managed Care Quality Strategy or other chosen quality metrics. Health Plans are not constrained to the chosen quality metrics used in the payment initiatives and may describe any innovations or unique features of its quality measures in this field.

- g. For “Internal Data Tracking”, the Health Plan shall describe how the Health Plan uses data for tracking activities and spending associated with a given Named Initiative, including whether the Health Plan uses a standard or customized claims form to notate value-based payments, what forms are used with providers for tracking value-based payments, what fields in those forms are used for tracking value-based payments, and what tables and databases are used for tracking value-based payments. Because value-based payment reform represents a new area for health informatics, it is important for Health Plans to share how they are collecting, processing, and administering data internally as it pertains to value-based payment activities and spending.
- h. “Race, Ethnicity, and Social Determinants”, the Health Plan shall describe if and how race and ethnicity are incorporated into this Named Initiative including if it is incorporated into a risk adjustment model, how social determinants are measured and used, and how racial and ethnic disparities are considered and incorporated to mitigate these inequalities.
- i. For “Complex Health Needs”, the Health Plan shall describe if and how this Named Initiative incorporates and considers individuals with complex health care needs.
- j. For “Primary Care” the Health Plan shall describe if and how this Named Initiative enhances care coordination and primary care.
- k. For “Behavioral Health”, the Health Plan shall describe if and how this Named Initiative enhances care coordination and behavioral health, including substance use disorder and mental health.
- l. For “Women’s Health”, the Health Plan shall describe if and how this Named Initiative enhances care coordination and women’s health including maternity care.

m. For “Plan’s Self-Evaluation of the Initiative”, the Health Plan shall describe for this Named Initiative:

- 1) Key evaluation activities
- 2) Timelines for planning, implementation, and evaluation
- 3) Stakeholder engagement and communication
- 4) Feedback or results including impact, outcomes, or consequences
- 5) Challenges experienced with the Named Initiative
- 6) Whether the Named Initiative is a pilot or not
- 7) Whether the Named Initiative is successfully working or not and how the Health Plan is measuring success or effectiveness.
- 8) Areas of innovation, unique characteristics, public health significance and importance, or direct relevance to Med-QUEST’s Quality Strategy.

5. The Health Plan shall complete all the questions to help classify which payment category the Named Initiative is classified under the HCP LAN APM Framework. Each Named Initiative may have payments that span over multiple HCP LAN APM Framework categories, and the IIDF is intended to help make it clear which initiatives have which types of payment categories under the APM Framework.

a. For the following fields, the Health Plan shall respond “Yes” or “No” in regards to the specific initiative:

- 1) HCP LAN Category IV:
 - i IV. Is the Named Initiative a population-based payment?
 - ii IV.A. Is the Named Initiative a population-based payment condition specific e.g. oncology or mental health?
 - iii IV.B. Is the Named Initiative a comprehensive population-based payment, e.g. global budget or

percent of premium payments?

- iv IV.C. Is the Named Initiative a comprehensive population-based payment in an integrated system?
- v IV.N. Is the Named Initiative a capitated payment with no quality incentive tied in?
- vi IV.R. Is the Named Initiative a capitated payment with risk adjustment?

2) HCP LAN Category III:

- i III. Does the Named Initiative payment model incorporate a fee-for-service architecture or payment?
- ii III.A. Does the Named Initiative have shared savings with upside risk only (no downside risk)?
- iii III.B. Does the Named Initiative have shared savings with downside risk, e.g. episode-based payments or comprehensive risk-based payments (not capitated)?
- iv III.N. Is the Named Initiative a risk-based payment with no quality incentive tied in?

3) HCP LAN Category II:

- i II. Is the Named Initiative a fee-for-service payment linked to quality?
- ii II.A. Does the Named Initiative have a foundational payment for infrastructure and operations, e.g. care coordination and health IT investments?
- iii II.B. Does the Named Initiative have pay-for-reporting?
- iv II.C. Does the Named Initiative have pay-for-performance?

4) HCP LAN Category I:

- i I. Does the Named Initiative have fee-for-service with no link to quality and value?

- b. For the following fields, the Health Plan shall provide narrative and descriptive comments about each Named Initiative by payment category as follows:

1) HCP LAN Category IV:

- i For "Category 4 Narrative/General Comments": The Health Plan shall describe the Category 4 payment features for the Named Initiative, including how the per member per month (PMPM) payment is made, payment cycle and when payments are made, to whom, and consideration of any other specific factors such as region, risk scores, other factors and considerations.

2) HCP LAN Category III:

- i For "Category 3 Narrative/General Comments": The Health Plan shall describe the Category 3 payment features for the Named Initiative including a description of the payment architecture, upside and downside risk, and other shared savings features as well as payment cycle and when payments are made.

3) HCP LAN Category II:

- i For "Category 2 Narrative/General Comments": The Health Plan shall describe any features of the Category 2 payment of the Named Initiative, including comments on quality, pay-for-reporting, pay-for-performance, or infrastructure as well as payment cycle and when payments are made.
- ii For "Category 2 Infrastructure Comments": The Health Plan shall describe any improvements for infrastructure and when payments are made.
- iii For "Category 2 Timeline Comments": If Field 19 "19 II.B. Does the Row 1 Initiative have pay-for-reporting?" is marked yes, the Health Plan shall describe the Health Plan's timeline to shift away from pay-for-reporting (II.B) to pay-for-performance (II.C).

4) HCP LAN Category I:

- i For "Category 1 Narrative/General Comments": The Health Plan shall describe the Category 1 payment features for the Named Initiative and when payments

are made.

- c. The Health Plan shall describe the Organizational Architecture and Organizational Integration with individual and organizational providers and enumerate the number of participating providers as follows:
 - 1) For “The number of individual professional providers participating” the Health Plan shall enumerate the number of individual professional providers who are participating in the Named Initiative.
 - i For “Comments on the arrangements with individual providers in field 24” the Health Plan shall describe the arrangements with professional providers.
 - 2) For “The number of institutional providers participating” the Health Plan shall enumerate the number of institutional providers who are participating in the Named Initiative.
 - i For “Comments on the arrangements with institutional providers in field 26” the Health Plan shall describe the arrangements with institutional providers.
 - 3) For “Organizational Architecture Comments”: The Health Plan shall describe how the Health Plan contracts with different provider organizations participating in the payment model and respond qualitatively to the following questions:
 - i Does the health plan contract with both individual professional providers and group practices or other physician organizations?
 - ii How does the Health Plan pay individual providers who are based at an institutional provider? If institutional providers pay individual professionals on a salaried basis, how does the Health Plan pay the individual professional provider?
 - iii What role does the Health Plan play, if any, in enhancing integration of different providers (e.g., between professional and institutional)?
 - iv Does the Health Plan benchmark individual professional

provider annual payments and if so, how does it do so?

- d. For “General Comments” the Health Plan shall describe any specific topics or questions related to this specific payment initiative or value-based payment in general. The Health Plan may describe organizational vision, philosophy, or future plans regarding reforms or redesign of payment initiatives including as it pertains to organizational architecture and integration and changes in contractual structures with providers, as well as changes in data architecture needed for improved value-based payment initiatives.

H) **Section 2:** In the embedded Excel document (Aggregate Level Data File (ALDF)), the Health Plan shall enter numerical data into all applicable cells. If the cell is not applicable, enter 0.

1. The Health Plan shall include all payments on an incurred basis, including both incurred and paid amounts. All payments made by plans to providers for all payment initiatives identified in the IIDF (Section 1) shall be counted in ALDF.
2. The Health Plan shall enumerate the total number of providers in the VBP Provider Type & APM Category, and the number of members attributed to the arrangements.
 - a. Member attribution methods may vary across HCP LAN APM Categories and VBP Provider Types.
 - b. Health Plans are asked to describe the attribution method used for each initiative in the IIDF.
 - 1) Precise attribution is required for initiatives where the payments made or assessed to providers are determined in any part by the members attributed to the initiative.
 - c. Where attribution methods are not used to determine payments made or assessed (e.g. purely fee for service arrangements), the Health Plan is asked to include members seen by the providers in those categories during the reporting period.
3. If any payment arrangements have a specified incentive/bonus payment or penalty that may be assessed, the Health Plan shall estimate both the potential incentive/bonus or penalty payment, as well as the actual

incentive/bonus payment or penalty assessed.

4. The Health Plan shall include the total cost of care during the reporting period for all members counted within a given VBP Provider Type x APM Category.
 - a. Then, the Health Plan shall parse the total cost of care of the members counted within a given arrangement that was at risk for members within VBP Arrangements. This reporting will support an understanding of the extent to which the member's cost of care across all care settings is at risk (e.g., a primary care arrangement may be at risk for the member's total cost of care including hospitalizations, specialist, and pharmacy costs) within the VBP Arrangement.
5. The Health Plan shall provide the total dollars incurred or paid for provider payment arrangements, both excluding and including exclusively FFS contracts.
6. The Health Plan shall include all payments to providers or entities for which the payment aligns with one or more of the APM categories.
7. In order for a payment arrangement to qualify as a value-based payment, there must be a meaningful quality component.
8. Arrangements without a meaningful quality component should be listed under one or more non-VBP Categories (i.e. 1F, 3N or 4N as applicable).
9. Payments made based on Diagnostic Related Groups (DRG) shall be treated as non-VBP payments unless coupled with one or more VBP arrangements.
10. If a provider is in multiple payment initiatives that span different APM categories, then the provider may be included multiple times in the rows that correspond to those categories; in these cases, the Health Plan shall parse amounts incurred or paid by APM category.
11. For payments under a single initiative that spans multiple APM categories, the Health Plan shall use the most advanced category. If, for example, a single initiative includes a shared savings arrangement with a pay-for-performance component, such as a quality incentive pool, then

the Health Plan shall put the total value of the contract in Category 3A for shared savings because 3A (shared savings) is more advanced than 2C (pay for performance).

12. It is generally expected that a single billing provider can be exclusively categorized into a single VBP Provider Category. If exceptions arise (e.g., where a provider can be attributed to two or more VBP Provider Types), the provider may be listed multiple times in the rows that correspond to those provider types; in these cases, the Health Plan shall parse amounts incurred or paid by VBP Provider Type.

- a. The "Hospital" provider type specifically shall exclude non-traditional services provided in a hospital setting that are better classified under another VBP Provider Category. For example, the Hospitals shall additionally be classified as a Primary Care Provider if it includes an outpatient primary care clinic, or as an LTSS provider if it includes long-term care services.

I) **Section 3:** The Health Plan shall submit a Provider-Level Data File (PLDF) annually.

1. The format of the PLDF is provided in the report template, and data fields are listed in the "VHC Reference Tables and Data Submission Formats" document.
2. The PLDF should include all providers who fall under any initiative listed in the IIDF, and therefore encompass all billing providers, regardless of payment arrangement, including but not limited to providers in exclusively FFS non-capitated arrangements.
3. General variables in the dataset that are not particular to this report are to be reported as defined by the "Health Plan Provider Network (HPS) File" in the HPMMIS Health Plan Provider Technical Guide.
4. Data shall be reported at the level of each individual billing provider or entity, and its corresponding payment initiative and payment category, and shall represent the disaggregated version of the aggregate metrics provided in Section 2.
5. For "VBP_INITIATIVE_NO" and "VBP_INITIATIVE_NAME", the Health Plan

shall identify every payment initiative the Provider is participating as identified in the IIDF. The "VBP_INITIATIVE_NO" shall correspond with to the "Initiative Number" and the "VBP_INITIATIVE_NAME" shall correspond to the "Name of Initiative" identified in the IIDF.

- a. A provider in multiple initiatives may be listed in multiple rows.
 - b. For example, an individual provider who provides some services under a fee-for-service arrangement, and other services under a pay-for-performance model initiative, will be reflected in two rows in the dataset, with each row reflecting data unique to that payment arrangement.
6. A provider classified under multiple VBP Provider Categories may be listed in multiple rows.
7. For "Provider APM Category" the Health Plan shall indicate the APM Category of the specific VBP Provider Type x Initiative corresponding to the particular row of data.
 - a. An initiative associated with multiple HCP LAN APM Categories shall only be associated with the most advanced category.
8. The total number of Providers, deduplicated by VBP Provider Type and Provider APM Category, should equal the number of Providers reported in the ALDF.
9. The "Provider APM Category Begin Date" is the start date of the payment arrangement for that provider.
10. The "Provider APM Category End Date" is the end date of the payment arrangement for the provider. If the provider remained active in the payment arrangement on the last date of the reporting period, the Health Plan shall list the end date as 12/31/2299.
11. For "Member Count Under Provider", the Health Plan shall include the sum of all members attributed to that Provider x VBP Provider Type x Initiative during the reporting period. Note that members included in a single Provider x VBP Provider Type x Initiative shall be unique, but the same member may be included in multiple Provider x VBP Provider Type x Initiative combinations as applicable.

- a. Member attribution methods may vary across HCP LAN APM Categories, Initiatives, and VBP Provider Types.
 - b. Where attribution methods are not used to determine payments made or assessed (e.g., purely fee for service arrangements), the Health Plan is asked to include members seen by the providers in those categories during the reporting period.
 - c. The total number of members, deduplicated by VBP Provider Type and Provider APM Category, should equal the number of Members reported in the ALDF.
12. For all members counted under a given Provider x VBP Provider Type x Initiative, the Health Plan shall report:
- a. The Total Cost of Care for all members counted
 - b. The Total Dollars (of the Total Cost of Care) at risk to the Provider under the Provider x VBP Provider Type x Initiative.
13. For “Provider Base Payment Amount”, the Health Plan shall report the base payment incurred or paid by the Health Plan to the provider under the selected payment model, not including incentives or penalties.
14. Potential and Actual Incentives, Bonus and Penalties:
- a. For “Provider Potential Incentive/Bonus Amount” and “Provider Incentive/Bonus Payment Amount”, the Health Plan shall estimate the potential and actual bonus/incentives and shared savings incurred or paid by the Health Plan to the provider under the VBP Provider Type x Initiative.
 - b. For “Provider Potential Penalties Amount” and “Provider Penalties Assessed Amount”, the Health Plan shall estimate the potential and actual penalties assessed for each provider under the VBP Provider Type x Initiative.
 - c. The potential incentive/bonus or penalty is the amount that each provider may incur for a given payment initiative and payment category, regardless of whether the bonus/incentive payment/penalty was incurred/made or incurred/assessed.

15. For "Physician Organization", the Health Plan shall indicate any larger entity with whom the provider is affiliated for the purposes of the payment arrangement. Affiliations not tied to payment arrangements relevant to this report need not be identified. The Health Plan shall use the "Physician Organization Ref" to populate the variable. If the Physician Organization is marked as Other (i.e. "I") then the Health Plan shall also enter the Physician Organization's name in "Physician Organization Other". If not, the Health Plan shall leave the "Other Physician Organization" field null.

- a. If the provider under a given VBP Provider Type x Initiative has payment arrangements with more than one Physician Organization, the Health Plan shall add an additional row to reflect that provider's additional membership(s), and accordingly parse their base payments, bonuses, and penalties arrangement.
- b. The fields "PO Base Payment Amount," "PO Potential Incentive/Bonus Amount," "PO Incentive/Bonus Payment Amount," "PO Potential Penalties Amount," and "PO Penalties Assessed Amount" shall capture any potential and actual PO- level payments for a given VBP Provider Type x Initiative as applicable.
- c. The fields "Member Count Under PO," "Total Cost of Care for Members Under PO" and "Total Dollars at Risk (of TCOC) for Members at PO Level" shall capture the same fields captured earlier at the Provider Level, now at the PO Level. It is expected that the member count and TCOC are likely to be aggregates of the provider-level data. The dollars at risk may be a simple sum or represent a more complex PO-level risk arrangement.

J) **Section 4:** The Health Plan shall submit a Member Attribution table (MAT) that corresponds with the PLDF. The purpose of this file is to identify all members attributed to providers and POs across all initiatives identified in the IIDF.

1. The format of the MAT is provided in the report template, and data fields are listed in the "VHC Reference Tables and Data Submission Formats" document.
2. The table should include all members included in all payment initiatives,

with one row per Member x Provider x PO x VBP Provider Type x Initiative combination.

- a. If Member Attribution is performed at the PO-level rather than at the Provider-level, each row may represent a Member x PO x VBP Provider Type x Initiative combination and Provider- Level Attribution Fields may be marked with NA (text fields) or 0 for numeric fields.
3. Data should be reported at the level of each individual member and should represent the disaggregated version of the aggregate metrics provided in Section 3, "Member Count Under Provider" and/or "Member Count Under PO," as applicable. The variables repeated from the PLDF should maintain referential integrity to data that was reported within the PLDF.
4. The member's Medicaid ID must be reported under "HAWI ID."
5. The "Member Attribution to Provider Begin Date" is the start date of the payment arrangement for that member with a given provider; "Member Attribution to PO Begin Date" is the corresponding start date of the payment arrangement for that member with the PO. The Health Plan may enter NA in the "Member Attribution to Provider Begin Date" field if attributions only occur at the PO Level.
6. The "Member Attribution to Provider End Date" is the end date of the payment arrangement for that member with a given provider; "Member Attribution to PO End Date" is the corresponding end date of the payment arrangement for that member with the PO. The Health Plan may enter NA in the "Member Attribution to Provider End Date" field if attributions only occur at the PO Level. If the member remained active in the payment arrangement on the last date of the reporting period, the Health Plan shall list the end date as 12/31/2299.
7. For "VBP_INITIATIVE_NO" and "VBP_INITIATIVE_NAME", the Health Plan shall identify every payment initiative the Provider is participating as identified in the IIDF. The "VBP_INITIATIVE_NO" shall correspond with to the "Initiative Number" and the "VBP_INITIATIVE_NAME" shall correspond to the "Name of Initiative" identified in the IIDF.

8. The Member may be listed as many times as needed to capture all applicable Member x Provider x PO x VBP Provider Type x Initiative attributions (or Member x PO x VBP Provider Type x Initiative attributions).
9. If the member has discontinuous segments in a given reporting period when the member was included in a given VBP arrangement, the Health Plan shall include multiple rows to reflect each of the attribution segments.
10. The "Amount Paid for the Member Under the Initiative" and "Total Cost of Care for Member" shall be listed per member. It is expected that if a member is listed multiple times, their Total Cost of Care will be identical across rows. The deduplicated sum of TCOC across all members should match when comparing the MAT, PLDF, and ALDF.

402.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance on the Value-Driven Health Care Report.

1. Percent of spending on VBP Arrangements (% Value-Based Arrangements, APM Category 2 or Higher, TOTAL): The Health Plan's aggregate spending on VBP as a percentage of the Health Plan's total spending on VBP and Fee For Service arrangements.
2. Diversity of VBP categories: The Health Plan has VBP arrangements in two or more VBP Provider Categories.
3. Percent Primary Care Providers in LAN Category 2 or Higher: Percentage of Primary Care Providers in LAN Category 2A or higher.
4. Percent Spend in LAN Category 3 or Higher: Percentage of Health Plan spend in LAN Category 3A or higher.
5. Percent Spend in LAN Category 4 or Higher: Percentage of Health Plan spend in LAN Category 4A or higher.
6. Active efforts to Implement VBP: The Health Plan described current strategies for advancement or new implementation of VBP arrangements in LAN category 2C or higher for at least two VBP Provider Categories.

7. Active efforts to address health disparities or complex health needs via VBP: The Health Plan utilizes VBP strategies or initiatives to address health disparities, individuals with complex health needs including behavioral health conditions, or both.

REPORT 403: PROVIDER NETWORK ADEQUACY VERIFICATION

403.1 Introduction

- A) The purpose of the Provider Network Adequacy (PNA) Report is to monitor the Health Plan's compliance with the network adequacy requirements and provide an in-depth quantitative and qualitative review of the provider network adequacy criteria.

403.2 Applicable Contract Sections

- A) Section 6.2.E.1. (Report Descriptions, Provider Network/Services) describes the requirements of the Provider Network Adequacy Verification Report.
- B) Section 8.1.B (Provider Network) describes the specific minimum requirements of the provider network.
- C) Section 8.1.D (Geographic Access of Providers) describe time and distance standards for the provider network.
- D) Section 8.1.I (Telehealth Services) enables the use of telehealth to enhance provider access.

403.3 Terms and Definitions

- A) **Self-Directed Provider count** should include the individuals providing chore services, not the payroll company.
- B) **Rather than counting a Federally Qualified Health Center (FQHC) as a single provider and assigning members and costs to that FQHC**, Health Plans should instead note the number of members assigned to the FQHC and divide them across the providers at that FQHC. Health Plans should report as if there is an equal distribution of members across the providers listed at the FQHC.

403.4 Methodology

- A) **This Report is organized into three sections. The methodology used to support all the analyses presented in Sections 1, 2 and 3 in the report is provided below.**

1. In Section 1, the Health Plan shall provide a Provider Level Data File that

contains record-level data that supported the reporting of the aggregate metrics in Section 1.

2. In Section 2, the Health Plan shall provide a Member Level Data File that contains record-level data that supported the reporting of the aggregate metrics in Section 1.
3. In Section 3, the Health Plan shall qualitatively evaluate remaining gaps in its provider network and describe its strategies to addressing or closing those gaps. Furthermore, in this section, the Health Plan shall explain actions taken to address the unmet KPI metrics for the prior quarter.

B) The Health Plan shall group providers into "PNA Provider Category" using the following method:

1. First, providers who are designated as primary care providers (PCPs) to any members are classified as PCPs for the purposes of this report, and categorized as either "Primary Care (Adult)" and "Primary Care (Child)," based on specialty or dominant population served (adults or children) and stored in a variable called "PNA Provider Category" in the PLDF.
2. In the PLDF, Health Plans will need to identify PCPs, physician assistants (PAs) and nurse practitioners (NPs) to the greatest specificity possible. Do not automatically default to primary care. If a provider is being contracted under both a specialty and a PCP, the HP needs to include that provider twice (once under PCP and once under specialty). These are the values found in the PNA Provider Category column of the Provider Group-PNA Category tab.
3. Next, the Health Plan shall refer to "PNA_Reference Tables and Data Submission Formats" in this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder to map the remaining provider types to PNA Provider Categories.

C) The mapping shall be completed in two steps:

1. First the Health Plan shall use the "PNA Provider Type Ref" tab to map Provider Types to the PNA Category (i.e. PNA_CAT).
2. For records where the PNA Category variable is "Various*" after mapping the table to the Health Plan's list of providers, the Health Plan shall use

the "PNA Provider Specialty Ref" table to map the remaining providers to the PNA Category.

- D) All Primary Care Providers, shall be classified as "Primary Care (Adult)" or "Primary Care (Child)" as defined in the "PNA Provider Specialty Ref" tab of the PNA reference table.
- E) The Health Plan shall parse the following single "PNA Category" into two PNA Categories based on information available to the Health Plan:
 - 1. Parse "Interpreters" into Sign Language Interpreters and Other Language Interpreters
 - 2. Parse "Emergency Medical Transportation" providers into "Emergency Medical Transportation (ground)" and "Emergency Medical Transportation (air)" providers.
- F) The Health Plan shall use the information in the "Provider Group- PNA Category" tab to map any remaining PNA provider category to Provider Group.
- G) Rules for classifying/counting providers:
 - 1. If a provider practices on two islands, the provider may be included on each island.
 - 2. If a provider has two practice locations on the same island, but both are rural or both are urban, the Health Plan must select one of the practice locations as the primary location to avoid double counting the provider.
 - 3. If a provider has two practice locations on the same island, but one is rural and the other is urban, the Health Plan may count the provider twice.
 - 4. In cases where a provider is counted two times, the Statewide Data should reflect a deduplicated count of providers such that the provider is not counted twice in the total number of contracted providers in any given PNA Provider Category.
 - 5. A provider may appear in two different provider groups. For example, a cardiologist who also serves as a PCP to some members may be listed both as a PCP in the "Primary Care" provider group, and as a specialist in

the “Specialists” provider group. A hospital that also provide waitlist beds may be included twice under separate Provider Groups – under “Acute Services” as well as “LTSS Providers.”

- a. Providers of Non-Emergency Medical Transportation and Non-Emergency Transportation (NEMT/NET) shall always be counted in two different provider groups: LTSS Providers, where network adequacy shall be assessed based on the appropriate members in managed LTSS; and Other, where network adequacy shall be assessed based on all members. The Health Plan shall either include the same set of NEMT/NET providers in both categories, or different sub-sets based on whether it contracts with NEMT/NET providers who exclusively serve LTSS or non-LTSS populations.

6. Duplications are only allowed in the statewide metrics reported for providers who belong in two or more distinct provider groups.

H) Providers who offer telehealth-based services may be included under the following circumstances:

1. The key role of telehealth in the context of a provider network adequacy analysis is to close network gaps, as opposed to infection control or alternative options for communication, although these are key advantages in other contexts.

Therefore, telehealth may be used in this report predominantly to close gaps or enhance the provider network.

2. Telehealth shall only be used to close network gaps for the provider types/types of services only for services that can be rendered via telehealth.
3. Rules for classifying/counting providers also apply to telehealth providers with some key distinctions.
4. Telehealth may be used to close gaps on neighbor islands, or in rural areas on Oahu. Therefore, a given provider in an urban area on one island willing to provide telehealth services in an urban area on another island may be included twice even within a given provider group. However, if the provider is located on the same island, the provider may

only be counted twice if they are located in an urban area, but additionally providing services via telehealth to members in a rural part of the island (and vice versa).

5. In all these instances, the statewide metrics must deduplicate providers within a single provider group.
6. For the purposes of this report, a given provider may only serve via telehealth on a single second island than the one on which they reside. In other words, a given provider may not be used to close network gaps on more than two islands for the purposes of this report even if they in theory can provide telehealth services statewide, to proxy a consideration for a given provider's capacity. If the provider is located outside Hawaii, they may only serve a single island via telehealth.
7. Providers with these services available will be labeled as Yes/No for the following categories:
 - a. PROV_PHYSICAL (all physical services and/or physical services but based out of state – e.g. DME/PERS) (Y/N)
 - b. PROV_VIRTUAL (in state telehealth provider and/or provider is physically in state but only provides telehealth (so not counted in physical network) (Y/N)

I) The Health Plan shall parse the member population into the following groups:

1. All - Total member population as of the first day of the reporting period
2. By age as of the first day of the reporting period into:
 - a. All adults, 21 years and older
 - b. Children (0 to <21 years)
 - c. Women of reproductive age (3-44 years): Female members who are 13 years or older, and younger than 45 years.
3. LTSS Members as of the first day of the reporting period:
 - a. The Health Plan shall use the definitions provided in the tab labeled "MLTSS Populations."

- b. First, any members who are not receiving services in the Managed LTSS (MLTSS) setting (i.e. MLTSS = No) shall be excluded.
- c. Next, members shall be sorted into the following groups:
 - 1) MLTSS members receiving institutional care services, identified as members in Nursing Facilities, Skilled Nursing Facilities, and/or Intermediate Care Facilities, including those who are wait-listed or in subacute facilities), identified as members with a Setting = NH, ICF, SA or WL.
 - 2) MLTSS members receiving HCBS, limited to those meeting Nursing Facility Level of Care, identified as members with a Level of Care = NF, and Setting = HCBS.
 - 3) MLTSS Members receiving HCBS, including "At Risk" members and those meeting Nursing Facility Level of Care, identified as members with a Setting = HCBS.
- 4. Additionally, the Health Plan shall use the tab labeled "Geographic Stratifications" to parse all members by residential zip codes into "urban" versus "rural."
- J) Drive time analysis results are reported in the MLDF and are used to calculate the drive time standard metrics reported in the PNA and NAAAR. The Health Plans shall then conduct a Driving Time Analysis (DTA) using geospatial software to calculate the driving times to providers for each member in their population as follows:
 - 1. First, the Health Plan shall parse the member and provider files by the six islands so that the software does not attempt to calculate driving times across islands.
 - 2. Driving times must be calculated using distances traveled on roads, as opposed to "as the crow flies" analyses, and must take into consideration the speed limits, traffic signs, and other road conditions on which the member would need to travel.
 - 3. The Health Plan shall use a tool that allows for the calculation of weekday driving times under typical driving conditions during non-peak hours (if the time can be set, then it shall be set to Mondays at 10:00 AM to allow

for comparable data generation); such options as “rural driving time” that allow for driving on unpaved roads is not allowed.

4. Additional settings:

a. Direction “Towards Facility” where Facility is the provider site

b. Restrictions (please check the following):

1) Avoid Limited Access Roads

2) Avoid Ferries

3) Avoid Unpaved Roads

4) Avoid Private Roads

5) Driving an Automobile

c. Drive Time Algorithm: Standard Drive Times (Fastest)

d. Leave Snap Tolerance at default options (Max Tolerance: 6; Min Tolerance: 0.1; Tolerance Distance units: Miles)

5. For each island, the Health Plan shall calculate the driving time from each member’s house to the closest provider in each PNA Provider Category.
6. In the case of Primary Care Providers for both adults and children, the Health Plan shall calculate the distance from the member’s residence to the member’s closest PCP.
7. For all other provider types, the Health Plan shall use the shortest driving time from the member’s residence to any provider in that category.
8. Using the DTA, members shall be parsed into those residing within 15 minutes, >15 and up to 30 minutes, >30 and up to 45 minutes, >45 and up to 60 minutes, or >60 minutes of a provider in that category.
9. A member should only appear in one of the five bucketed categories.
10. Only members in the populations served by the provider need to be counted. As an example, only members needing or utilizing BH services, as identified using the method described above, shall be considered in the

"Number of Members Served" and "# Members Residing...." PNA Provider Categories within the behavioral health Provider Group.

11. Statewide data shall represent an aggregate of the rural and urban data.
12. To calculate driving distances, the Health Plan shall parse its member population and provider population by island of residence/practice on the first day of the reporting period.
13. If a provider is available to a member via telehealth, the member driving time to the provider shall be zero minutes, unless the member's telehealth claims typically include an origination site that is non-residential. In these cases, the driving time shall be based on the distance from the member's residence to the origination site.

K) In **Section 1**, The Health Plan shall provide a Provider Level Data File (PLDF).

1. Specifications are provided in the "PLDF Data Submission Format" tab; field formats, values, and descriptions provide further details on various fields. The Health Plan shall include all providers enrolled on the first day of the reporting period.
2. The methods described within this report shall be used to assign all applicable providers to a PROVIDER_GROUP and PROV_PNA_CATEGORY. If a provider does not have a PNA Category, the Health Plan shall enter "N/A". Applicable tabs include: PNA Provider Type Ref and Provider Group-PNA Category
3. The following fields shall be filled out based upon the provider's physical practice location: PROV_PRACTICE_ZIP, PROV_ISLAND, PROV_RURALITY, PROV_ZIP_PC_HPSA, and PROV_ZIP_MH_HPSA.
4. A provider shall be identified as a PCP even if they are the assigned PCP to a single member. If a given PCP represents a group, clinic, health center, or other multi-specialty/multi-provider practices, then the field PCP_GROUP shall be used to indicate how many providers practice within the group.
5. Telehealth practice fields:

- a. PROV_PHYSICAL (all physical services and/or physical services but based out of state – e.g. DME/PERS) (Y/N)
 - b. PROV_VIRTUAL (in state telehealth provider and/or provider is physically in state but only provides telehealth (so not counted in physical network) (Y/N)
- 6. Per provider counting rules specified in this report, a provider shall be counted more than once and appear in more than one row of data in the following circumstances:
 - a. Provider has a physical practice location on more than one island
 - b. Provider has two physical practice locations on the same island, and one is in an urban setting and the other is in a rural setting
 - c. A provider fits one of the specific and exceptional circumstances where a provider may be counted appear twice in the same Provider Group, as described in this report.
 - d. A provider appears in two different provider groups
 - e. Where providers are counted more than once in the dataset, the telehealth fields shall only be completed as applicable. For example, if a provider serves as both a cardiologist and primary care physician, and provides telehealth visits as a cardiologist, only the cardiologist row will additionally have completed information in the telehealth fields.
- 7. The Health Plan shall identify providers who speak fluently in languages other than English in the PROV_NON_ENG field.
- L) In **Section 2**, the Health Plan shall provide a Member Level Data File (MLDF).
 - 1. Specifications are provided in the “MLDF Data Submission Format” tab; field formats, values, and descriptions provide further details on various fields.
 - 2. The Health Plan shall include all members enrolled on the first day of the reporting period.
 - 3. Data reported in the following fields shall be based on member

classification into one or more of the member groups defined in this report: MEM_ADULT, MEM_CHILD, MEM_BH, MEM_HCBSA, MEM_HCBS, MEM_INSTL, and MEM_REPR.

4. Member's who speak a non-English language at home, as identified in this report, shall be identified in MEM_ESL.
5. Member's geographic groupings (residential zip code, rurality, and whether the member resides in a primary care or mental health professional shortage area) attributed based on methods described in this report shall be reported in MEMBER_RES_ZIP, MEM_RURALITY, MEM_ZIP_PC_HPSA, and MEM_ZIP_MH_HPSA.
6. The remaining variables capture the shortest driving time from the member's residence to the closest provider in each "PNA Provider Category" and are captured using variables that begin with "TIME_".
7. Only include member address if the full address is available. Do not submit incomplete addresses.
8. MEM_SMI should be completed if member belongs to this group: members with an eligible SMI diagnosis.

M) In **Section 3**, the Health Plan shall qualitatively evaluate any gaps in its provider network and describe its strategies to addressing or closing those gaps. This includes filling out the QI_PNA_NAAAR_Qual_Template that provides justification and corrective actions that are currently underway to address the KPI shortcomings.

403.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance. KPIs will be based on three major standard types: minimum # of network providers, maximum time to travel, provider to enrollee ratios.

1. KPIs based on Minimum Number of Network Providers
 - a. Hospitals: 5 on Oahu, 1 on Maui, 1 on Kauai, 2 on Hawaii, 1 on Lanai and 1 on Molokai serving the adult and pediatric population by island.

- b. Emergency transportation: at least one ground and one air transportation serving the adult and pediatric population statewide.
- c. Non-emergency transportation: at least two providers identified as Non-Emergency Medical Transportation/Non-Emergency Transportation (NEMT/NET) Providers serving the adult and pediatric population statewide.
- d. Physician specialists: at least one of each, though not limited to, cardiologists, endocrinologists, general surgeons, geriatricians, hematologists, infectious disease specialists, nephrologists, neurologists, obstetrician-gynecologists, oncologists, ophthalmologists, orthopedists, otolaryngologists, pediatric specialists, plastic and reconstructive surgeons, pulmonologists, radiologists, and urologists, serving the adult and pediatric population statewide.
- e. Laboratory: at least one laboratory facility serving the adult and pediatric population statewide. Laboratories are defined as a facility with either a Clinical Laboratory Improvement Amendments (CLIA) 1988 certificate or a waiver of a certificate of registration.
- f. Optometrist: at least one provider identified as an optometrist serving the adult and pediatric population statewide.
- g. Pharmacies: at least one pharmacy serving the adult and pediatric population statewide.
- h. Other health care providers: at least one of each of the following provider types, including physical and occupational therapists, audiologists, and speech-language pathologists, serving the adult and pediatric population statewide.
- i. Other health care providers: at least one licensed dietician provider serving the adult and pediatric population statewide.
- j. Other health care providers: at least one physician assistant provider serving the adult and pediatric population statewide.
- k. Other health care providers: at least one community health worker serving the adult and pediatric population statewide.

- l. Other behavioral health providers: at least one of each of the following behavioral provider types, including Licensed Therapists, Counselors, and Certified Substance Abuse Counselors (CSACs), serving the adult and pediatric population statewide.
- m. Other behavioral health providers: at least one of each behavioral health provider types, including Peer Support Specialists certified by the Adult Mental Health Division (AMHD) as a part of their Hawaii certified peer specialist program or a program that meets the criteria established by AMHD, serving the adult and pediatric population statewide.
- n. Other behavioral health providers: at least one State-Licensed Special Treatment Facility for the provision of substance abuse therapy/treatment serving the adult and pediatric population statewide.
- o. Other health care providers: at least one durable medical equipment provider serving the adult and pediatric population statewide.
- p. Other health care providers: at least one case management agency serving the adult and pediatric population statewide.
- q. LTSS: at least one of each LTSS Provider type, including Adult Day Care Facilities, Adult Day Health Facilities, Assisted Living Facilities, Community Care Foster Family Home (CCFFH), Community Care Management Agency (CCMA), Expanded Adult Residential Care Homes (E-ARCHs), Home-Delivered Meal Providers, Non-Medical Transportation Providers, Nursing Facilities (NFs), Personal Care Assistance Providers, Personal Emergency Response System (PERS) Providers, Private Duty Nursing (PDN), Respite Care Providers, and Specialized Medical Equipment and Supply Providers, serving the adult and pediatric population statewide.
- r. Other behavioral health providers: at least one Providers of lodging and meals associated with obtaining necessary medical care serving the adult and pediatric population statewide.
- s. Interpretation services: At least one of each of the following

interpretation services, including sign language interpreters and interpreters for languages other than English, serving the adult and pediatric population statewide.

- t. Other health care providers: at least one Community Paramedic provider serving the adult and pediatric population statewide.
- u. Other health care providers: at least one Home Health Agency serving the adult and pediatric population statewide.
- v. Other health care providers: at least one Hospice provider serving the adult and pediatric population statewide.
- w. Specialist: at least one family planning provider serving the adult and pediatric population statewide.
- x. Facilities: at least one FQHC/RHC serving the adult and pediatric population statewide.
- y. Other health care providers: at least one of each provider type, certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, and behavioral health nurse practitioners, serving the adult and pediatric population statewide.

2. KPIs based on Maximum Time to Travel

- a. Primary care providers (Urban): at least 95 percent of members must have access to a primary care provider within 30 minutes driving time to an appointment, serving the adult and pediatric population in urban areas.
- b. Primary care providers (Rural): at least 95 percent of members must have access to a primary care provider within 60 minutes driving time to an appointment, serving the adult and pediatric population in rural areas.
- c. Specialists (Urban): at least 85 percent of members must have access to each specialist type within 30 minutes driving time to an appointment, serving the adult and pediatric population in urban areas.

- d. Specialists (Rural): at least 85 percent of members must have access to each specialist type within 60 minutes driving time to an appointment, serving the adult and pediatric population in rural areas.
- e. OB/GYNs (Urban): at least 95 percent of members must have access to an OB/GYN within 30 minutes driving time to an appointment, serving the adult and pediatric population in urban areas.
- f. OB/GYNs (Rural): at least 95 percent of members must have access to an OB/GYN within 60 minutes driving time to an appointment, serving the adult and pediatric population in rural areas.
- g. Adult Day Care/Adult Day Health (Urban, MLTSS): at least 95 percent of members must have access to an Adult Day Care or Adult Day Health provider within 30 minutes driving time to an appointment, serving the MLTSS population in urban areas.
- h. Adult Day Care/Adult Day Health (Rural, MLTSS): at least 95 percent of members must have access to an Adult Day Care or Adult Day Health provider within 60 minutes driving time to an appointment, serving the MLTSS population in rural areas.
- i. Hospitals (Urban): at least 95 percent of members must have access to a hospital within 30 minutes driving time to an appointment, serving the adult and pediatric population in urban areas.
- j. Hospitals (Rural): at least 95 percent of members must have access to a hospital within 60 minutes driving time to an appointment, serving the adult and pediatric population in rural areas.
- k. Behavioral Health Providers (Urban): at least 85 percent of members must have access to a behavioral health provider within 30 minutes driving time to an appointment, serving the adult and pediatric population in urban areas.
- l. Behavioral Health Providers (Rural): at least 85 percent of members must have access to a behavioral health provider within 60 minutes

driving time to an appointment, serving the adult and pediatric population in rural areas.

- m. Emergency Services Facilities (Urban): at least 95 percent of members must have access to an emergency services facility within 30 minutes driving time to an appointment, serving the adult and pediatric population in urban areas.
- n. Emergency Services Facilities (Rural): at least 95 percent of members must have access to an emergency services facility within 60 minutes driving time to an appointment, serving the adult and pediatric population in rural areas.
- o. LTSS Providers (Urban, MLTSS): at least 95 percent of members must have access to an LTSS provider within 30 minutes driving time to an appointment, serving the MLTSS population in urban areas.
- p. LTSS Providers (Rural, MLTSS): at least 95 percent of members must have access to an LTSS provider within 60 minutes driving time to an appointment, serving the MLTSS population in rural areas.
- q. 24-Hour Pharmacies (Urban): at least 95 percent of members must have access to a 24-hour pharmacy within 30 minutes driving time, serving the adult and pediatric population in urban areas.
- r. Pharmacies (Urban): at least 95 percent of members must have access to a pharmacy within 15 minutes driving time, serving the adult and pediatric population in urban areas.
- s. Pharmacies (Rural): at least 95 percent of members must have access to a pharmacy within 60 minutes driving time, serving the adult and pediatric population in rural areas.

3. KPIs based on Provider to Enrollee Ratio

- a. Primary Care Providers: at least one primary care provider must be available for every 300 members or fewer, serving the adult and pediatric population statewide.

- b. Psychiatrists: at least one psychiatrist must be available for every 150 members (or fewer) with a serious mental illness or a severe and persistent mental illness (SMI or SPMI), serving the adult and pediatric population statewide.
 - c. Other Behavioral Health Providers: at least one each behavioral health provider (psychologists, licensed mental health counselors, licensed clinical social workers, and APRNs – behavioral health) must be available for every 100 members (or fewer) with a serious mental illness or a severe and persistent mental illness (SMI or SPMI), and this requirement must be met for all provider groups, serving the adult and pediatric population statewide.
- 4. Health Plan Responses to Unmet KPIs
 - a. Health Plans accurately describe the unmet KPIs and mitigation measures undertaken to address these deficiencies for previous quarter.

REPORT 404: SUSPENSIONS, TERMINATIONS, AND PROGRAM INTEGRITY EDUCATION

404.1 Introduction

- A) Per CFR §438.608, the Health Plan shall submit a Suspensions, Terminations and Program Integrity Education (PIE) Report to DHS on a quarterly basis. The Health Plan shall submit this report for two distinct purposes:
1. Notification of provider suspension or termination: If the Health Plan suspends or terminates a provider because of suspected or confirmed fraud, waste and abuse, the Health Plan shall notify DHS using this report within three (3) business days.
 2. Quarterly summary of provider or employee suspensions or terminations and Program Integrity Education activities: On a quarterly basis, the Health Plan shall complete this report to provide a summary of:
 - a. Any providers who have been suspended, terminated, denied credentialing or voluntarily separated from the Health Plan in the reporting period;
 - b. Any employees who have been suspended, terminated, denied credentialing or voluntarily separated from the Health Plan in the reporting periods;
 - c. Any Program Integrity-specific education opportunities offered to providers and/or employees.
- B) DHS shall use the Suspensions, Terminations and Program Integrity Education (PIE) Report to adequately monitor changes to the Health Plan's provider networks due to provider suspensions or terminations.

404.2 Applicable Contract Sections

- A) Section 6.2.E.1.d (Report Descriptions) describes the requirements of the Suspensions, Terminations and Program Integrity Education Report.
- B) Section 6.2.F (Administration, Finances, and Program Integrity reports) includes the Suspensions, Terminations and Program Integrity Education Report.

- C) Section 12.2.A.8 (Fraud, Waste and Abuse (FWA)) lists the Suspensions, Terminations and Program Integrity Education Report as a required report on FWA activities.

404.3 Terms and Definitions

- A) **Suspension:** Per 42 CFR § 455.2, suspension means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.
- B) **Termination:** Per CMS Section 6501 of the Affordable Care Act Program Integrity Provisions, termination occurs when the Medicare program, State Medicaid program, or CHIP has taken an action to revoke a provider's billing privileges, a provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of a provider or supplier of the Medicare program, State Medicaid program, or CHIP that the revocation is temporary.
- C) **Program Integrity Education:** Training related to Program Integrity issues including, but not limited to, correct/incorrect coding practices or proper/improper claims submissions. The training may be as a result of pre-payment or post-payment claims review or to prevent fraud, waste and abuse.

404.4 Methodology

- A) **This report is organized into four sections:**
- B) **Section 1: Provider Suspensions and Terminations in three (3) business days**
1. The Health Plan shall complete the embedded Excel template listing all providers (e.g. physicians, non-physicians, facilities, agencies, suppliers, etc.) that are suspended or terminated, either voluntarily or involuntarily, because of suspected or confirmed fraud and abuse. The Health Plan shall provide the following pieces of information:
 - a. Date Reporting
 - b. Health Plan Name

- c. Provider's Last Name
 - d. Provider's First Name
 - e. Provider's Medicaid ID #
 - f. Provider's NPI #
 - g. Last 4 Digits of Provider SSN
 - h. Provider Type
 - i. Provider Specialty (if applicable)
 - j. Provider's Primary City & Island of Service
 - k. Suspension (S) or Termination (T)
 - l. Effective Date of Suspension or Termination
 - m. Reason for Suspension or Termination
 - n. Length of Suspension (if applicable)
 - o. Reason for Action(s) Taken (narrative)
 - p. Was the case that led to this provider suspension or termination referred to the State?
 - q. Date of Referral to State
2. The Health Plan shall report provider suspensions and terminations within three (3) business days. When submitting Section 1 to DHS, the Health Plan shall complete Section 1 and the Attestation section of the report template and provide attachments as needed.

C) Section 2: Provider Suspensions, Terminations, or Denied Credentialing Summary Information

- 1. The Health Plan shall use the embedded Excel file "PIE Section 2 Suspensions and Terminations" to provide a list provider suspensions and terminations during the reporting period. The Health Plan shall provide the following pieces of information:

- a. Effective Date of Suspension or Termination
 - b. Date Suspension or Termination Reported to DHS (the health plan is only required to fill in this column in the PLDF 2 for providers suspended or terminated for fraud, waste, or abuse)
 - c. Provider's Last Name
 - d. Provider's First Name
 - e. Provider's NPI#
 - f. Provider's Medicaid ID#
 - g. Provider's Specialties (if any)
 - h. Provider Type (according to PMR)
 - i. Provider's Primary City/Island of Services
 - j. Suspension (S) or Termination (T)
 - k. Duration of Suspension (if applicable)
 - l. Reason for Action Taken (narrative)
2. The Health Plan shall use the embedded Excel file "PIE Section 2 Denied Credentialing" to provide a list of providers denied credentialing during the reporting period. The Health Plan shall provide the following pieces of information:
- a. Date Credentialing Denied
 - b. Provider's Last Name
 - c. Provider's First Name
 - d. Provider's NPI #
 - e. Provider's Medicaid ID #
 - f. Provider's Specialties (if any)
 - g. Provider Type (according to PMR)

- h. Provider's Primary City/Island of Services
- i. Reason Denied Credentialing (narrative)
- j. Was this provider under investigation for suspected fraud or abuse at the time their credentials were denied?

D) Section 3: Program Integrity Provider Education and Training

1. The Health Plan shall provide a list of all program integrity education (including memos, policies, and guidance transmitted to the providers) and training given to providers during the reporting period.
2. This list should focus on education and training given to providers as a result of pre-payment or post-payment claims review where a provider or employee was identified as committing potentially fraudulent or abusive activity. The list should include education for both individual providers and group training sessions.
 - a. The Health Plan shall provide the following pieces of information:
 - 1) Date of Education or Training
 - 2) Provider Last Name
 - 3) Provider First Name
 - 4) Provider Medicaid ID #
 - 5) Provider NPI #
 - 6) Provider Type
 - 7) Provider Specialty (if applicable)
 - 8) Education or Training Topic
 - 9) Reason for Education or Training
 - 10) Corrective Action Plan Required
 - 11) Health Plan Employee Doing Education/Training

E) Section 4: Employee Suspension and Termination

1. The Health Plan shall provide a summary of all employees (both Health Plan employees and subcontractors) who resigned, were suspended, were terminated, or voluntarily withdrew from employment as a result of suspected or confirmed fraud and abuse. The Health Plan shall provide the following pieces of information:
 - a. Employee/Subcontractor Name
 - b. Department/Subcontractor Company Name
 - c. Hire Date
 - d. Suspension (S)/Termination (T)/Voluntary Withdrawal (VW)/Resigned (R)
 - e. Suspension/Termination/Voluntary Withdrawal Start Date
 - f. Reason for Suspension/Termination/Voluntary Withdrawal
 - g. Duration of Suspension (if applicable)
 - h. Name of Employee's Supervisor

404.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. Percent of suspended/terminated providers due to fraud, waste, or abuse reported to the State within 3 business days.

404.6 Special Submission Instructions and Timelines for Submission

A) Health Plans shall use the Suspensions, Terminations and Program Integrity Education Report (PIE) to submit any instance of provider suspension or termination, whether voluntary or involuntary, for suspected or confirmed fraud, waste or abuse to DHS within three (3) business days of the suspension or termination.

1. Health Plans shall check the box in the "Health Plan Submission Information" section of the template indicating that this report is of a provider suspension or termination notification.
2. The Health Plan will then complete Section 1 and the Attestation section

of the Report and shall include any necessary attachments.

- B) Health Plans shall submit the remainder of the Suspensions, Terminations and Program Integrity Education Report to DHS on a quarterly basis per the General Reporting Instructions.

REPORT 405: FQHC/RHC SERVICES RENDERED

405.1 Introduction

- A) The Health Plan shall provide DHS a report on all services rendered by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) on a quarterly and annual basis.
- B) DHS uses FQHC/RHC Services Rendered Report to ensure the in- network and out-of-network FQHCs and RHCs receive reimbursement for the services rendered to each MCO's members equal to the amount the provider is entitled to under the Benefits Improvement and Protection act of 2000 (BIPA).

405.2 Applicable Contract Sections

- A) Section 7.2.C.1 – Provider and Subcontractor Reimbursement describes how the Health Plan shall report visits provided to its members by FQHCs and RHCs and any payments made to the FQHCs and RHCs by the Health Plan.

405.3 Terms and Definitions

- A) **Federally Qualified Health Center (FQHC):** An entity that has be determined by the Secretary of the DHHS to meet the qualifications for an FQHC, as defined in section 1861(aa)(4) of the Social Security Act.
- B) **Rural Health Center (RHC):** An entity that meets the qualifications for an RHC, as defined in Section 1861(aa)(2) of the Social Security Act.
- C) **Prospective Payment System (PPS) Rate:** A method of reimbursement in which claim payment is made based on a predetermined, fixed amount.
- D) **MCO_ID:** QUEST Assigned Health Plan identification number.
- E) **MCO_NAME:** QUEST Assigned Health Plan name. The Health Plan shall limit responses to:
 - 1. ALOHACARE
 - 2. HMSA
 - 3. KAISER

4. OHANA

5. UNITED

- F) **REPORT_DATE:** Date of Data Extract. The Health Plan shall format this date as DD/MM/YYYY.
- G) **CLINIC_NAME:** The FQHC/RHC Clinic Name. The Clinic Name may be associated with more than one Billing Provider Number and Name when the Clinic has satellite facilities. Refer to the "FQHC RHC Clinics 20210225.xlsx" file in the report's subfolder of the "Report Reference Tables and Data Submission Formats" folder to map Clinic Name to Billing Provider Number and Name.
- H) **BILLING_PROVIDER_NUMBER:** The QUEST assigned PROVIDER NUMBER for the FQHC/RHC facility. There may be multiple Billing Provider Numbers for each Clinic if the Clinic has satellite facilities. Use the "FQHC RHC Clinics" Excel file to map Billing Provider Number to Clinic Name and Billing Provider Name.
- I) **BILLING_PROVIDER_NAME:** The QUEST assigned PROVIDER NAME of the FQHC/RHC facility. There may be multiple Billing Provider Names for each Clinic if the Clinic has satellite facilities.
1. Use the "FQHC RHC Clinics" Excel file to map Billing Provider Name to Clinic
 2. Name and Billing Provider Number.
- J) **RENDERING_PROVIDER_NUMBER:** The Rendering Provider's Medicaid Provider identification number.
- K) **RENDERING_PROVIDER_NAME:** The Rendering Provider's name.
- L) **CONTRACT_STATUS:** Whether the Health Plan is contracted with the FQHC/RHC. If the Health Plan is contracted with the FQHC/RHC, the value of Contract Status shall be "PAR". If the Health Plan is not contracted with the FQHC/RHC, the value of Contract Status shall be "Non-PAR".
- M) **RPT_BEGIN_DATE:** For the Provider Level Data File, the beginning date of the reporting period. For an annual report, this will be the beginning date of the calendar year. For a quarterly report, this will be the beginning date of the

quarter. The Health Plan shall format this date as DD/MM/YYYY.

- N) **RPT_END_DATE:** For the Provider Level Data File, the ending date of the reporting period. For an annual report, this will be the ending date of the calendar year. For a quarterly report, this will be the ending date of the quarter. The Health Plan shall format this date as DD/MM/YYYY.
- O) **CLAIM_BEGIN_DATE:** For the Claim Level Data File, the beginning date on the claim/encounter.
- P) **CLAIM_END_DATE:** For the Claim Level Data File, the ending date on the claim/encounter.
- Q) **MEMBER_FIRST_NAME:** The member's first name.
- R) **MEMBER_LAST_NAME:** The member's last name.
- S) **MEMBER_ID_NUMBER:** The member's Medicaid identification number.
- T) **PATIENT_ACCOUNT_NUMBER:** The billing provider patient account number being submitted for the report.
- U) **CLAIM_STATUS:** The Status of the claim at the time of reporting. Please limit values to the following:
1. Paid
 2. Denied
 3. Reversed
- V) **HP_CLAIM_NUMBER:** The Health Plan Claim identification number.
- W) **HP_CLAIM_NUMBER_DETAIL_LINE:** The Numeric Detail Line Number of the claim.
- X) **MQD_CRN:** The 15 digit CRN assigned to the claim once it is submitted to HPMMIS as an encounter.
- Y) **PLACE_OF_SERVICE_CODE:** The Place of Service Code on the claim.
- Z) **PROCEDURE_CODE:** The Procedure Code on the claim line. AA) **PROCEDURE_CODE_DESCRIPTION:** The Procedure Code Description.

- AA) **DATE_PAID:** Date claim was adjudicated. The Health Plan shall format this date DD/MM/YYYY.
- BB) **BILLED_AMOUNT:** Billed amount from detail line of claim.
- CC) **CO-PAYMENT:** Amount member responsible for from the detail line of claim.
- DD) **PAID_AMOUNT:** Medicaid paid amount for detail line of claim.
- EE) **PRIMARY/SECONDARY:** Whether Medicaid was the Primary payer or Secondary payer for the claim. The Health Plan shall limit responses to "Primary" and "Secondary".
- FF) **PRIMARY PAYER:** Name of the Primary Insurance listed on the claim. Note: The primary insurance listed on the claim should be reported regardless of payment.
- GG) **COUNT_OF_FFS_CLAIMS/ENCOUNTERS:** The number of claims/encounters paid FFS or PPS as of the report run date.
- HH) **COUNT_OF_CAP_CLAIMS/ENCOUNTERS:** The number of claims/encounters covered by the capitated payment.
- II) **FFS_PAYMENTS:** Claim service payments made to the FQHC/RHC on claims with service dates during the reporting period.
- JJ) **CAP_PAYMENTS:** Capitation payments the clinics earned during the reporting period (example: per member per month payments). Note: It is expected for capitation payments to not be claim driven. It is possible for there to be capitation payments reported with no capitation encounters.
- KK) **ADMIN_PAYMENTS:** Negotiated administrative fees the clinics earned during the reporting period. Admin payments should be reported in the period they are earned/accrued. If there is no accrual and the earned amount is not determined until the year end, then the payment would only be reported on the yearend report.
- LL) **INCENTIVE_PAYMENTS:** Performance incentives the clinics earned during the reporting period. Incentive payments should be reported in the period they are earned/accrued. If there is no accrual and the earned amount is not determined until the year end, then the payment would only be reported on

the yearend report.

MM) **PRIMARY_FFS_PAYMENTS:** The total FFS paid amount where Medicaid was the primary payer on the claim.

NN) **SECONDARY_FFS_PAYMENTS:** The total FFS paid amount where Medicaid was the secondary payer on the claim.

OO) **TOTAL_HEALTH_PLAN_PAYMENTS:** Sum of CAP_PAYMENT, ADMIN_PAYMENT, INCENTIVE_PAYMENT, PRIMARY_FFS_PAYMENTS, SECONDARY_FFS_PAYMENTS.

PP) **THIRD_PARTY_LIABILITY:** The amount for which a third party was responsible.

405.4 Methodology

A) **This report is organized into two file types which the Health Plan shall provide DHS on an annual and a quarterly basis:**

B) In **Section 1: Health Plan Summary Report**, the Health Plan shall provide a summarized report on all claims and encounters for each FQHC and RHC Clinic based on date of service.

C) In **Section 2: Health Plan Claim/Encounter Line Detail Report**, the Health Plan shall provide line level detail of all claims for which Medicaid is the primary or secondary payer for each Clinic for which the Health Plan has claims and encounters during the reporting period. The Health Plan shall complete one consolidated Excel template that includes all providers, including claims where Medicaid was primary or secondary payer.

D) For Fee-for-service based payments, this will include all claims with a service during the time period specified and paid as of the report run date.

E) For all capitation-based FQHC/RHC claims payments, this will include all claims for services paid and encounters set to "final adjudication" as of the report run date.

F) Each Clinic's Health Plan Claim/Encounter Line Detail Report shall include all satellite facilities (e.g. all Billing Provider Numbers) associated with that FQHC or RHC Clinic.

405.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. Percent of data elements populated in the Health Plan Summary Report file
2. Percent of data elements populated in the Health Plan Claim/Encounter Line Detail Report file
3. The Health Plan Summary Report file includes all active FQHC/RHCs for the reporting period
4. Percent of FQHC/RHCs present in the Health Plan Summary Report file with records in the Claim/Encounter Line Detail Report file
5. The Health Plan Summary Report and the Health Plan Claim/Encounter Line Detail reports were submitted within the requested time frame

REPORT 406: TIMELY ACCESS

406.1 Introduction

- A) The purpose of this report is to monitor the Health Plan's compliance with the standards for members' timely access to care.
- B) The report will be based on a shared Secret Shopper Survey conducted on the entire Quest Integration Provider Network on behalf of all Health Plans. A combined list of Providers from all Health Plans will be used to generate provider samples. Then, the distribution of members across plans will be used to assign each provider in the sample to a given Health Plan for the purposes of the survey. The Secret Shopper caller shall identify as a member of the Health Plan to which a given provider is attributed to. A standardized protocol focused on obtaining appointments shall be followed across all calls placed. More details on the methodology are provided below.

406.2 Applicable Contract Sections

- A) Section 6.2.E.c. describes the Timely Access Report
- B) Section 8.1.C, related to Availability of Providers

406.3 Terms and Definitions

- A) **Secret Shopper Survey:** A method for collecting appointment data pertaining to members' timely access to care. A caller contacts an individual provider and simulates a patient appointment request in order to measure time lapse between the request for care and the day and time of the appointment offered to the caller.
- B) **Secret Shopper:** A covert investigator who contacts a Health Plan contracted provider and simulates an appointment request from a QUEST member who is a member of the Health Plan.

406.4 Methodology

- A) **This report is organized into three sections,** both providing the same types of metrics derived from a secret shopper survey. For methodology and protocol please refer to "TAR Reference Tables and Sampling Frame" in the "Report Reference Tables and Data Submission Formats" folder.

- B) Health Plans shall collaborate to engage a single timely access survey contractor in order to conduct the telephone-based “secret shopper” survey on behalf of all Health Plans using a standardized protocol for the entire Quest Integration provider network.
1. DHS may contract with the timely access survey contractor on behalf of all Health Plans to promote standardization and collaboration
 - a. In this model, the Health Plans shall remain responsible to DHS for monitoring the timely access survey contractor’s performance and delivery of high-quality data to support their assessment and verification of timely access standards.
 - b. The Health Plans shall agree to all the Health Plan responsibilities identified within DHS’ contract with the timely access survey contractor.
 - c. The Health Plans may provide general information, but shall not compromise the integrity of the timely access assessments by providing any specific information on the sampling frame, sample, member names or any other aspect of the survey protocol to providers or their schedulers.
 - d. Should DHS require additional data collection to support closer monitoring by one or more Health Plans as specified in RFP-MQD-2021-008 Section 6.2.E.1.c, the Health Plan(s) may independently contract with the timely access contractor for supplemental data collection or collaborate with DHS to modify and supplement the DHS contract; this decision will be made collaboratively by the affected Health Plan(s) and DHS. In such instances, a payment allocation method specific to the supplemental contract with the timely access survey contractor will be developed.
- C) The survey is intended to test the appointment systems of providers from each provider type category with contractually required timely access standards.
- D) Each Health Plan will be responsible for a share of the sampled providers proportionate to the number enrollees that they serve.
- E) If the Health Plan is exempted from covering an area then it is not responsible

for surveying providers in that locale.

F) Secret Shopper Survey Protocol – The Secret Shopper Survey Protocol is parsed into six key steps, listed below:

1. Defining the Provider Population
2. Defining the Sampling Frames
3. Generating the Sample
4. Assigning Sampled Providers to Health Plans
5. Conducting the Survey
6. Canceling any appointments made

G) Sample Frame. The Health Plan shall follow the protocol outlined in the “TAR Sampling Guide And Secret Shopper Survey Protocol” document in the “Report Reference Tables and Data Submission Formats” folder to draw a representative stratified random sample of providers to receive secret shopper calls. The guide includes instructions for which providers to sample each quarter and what manner of call they are to receive, from a simulated new patient or a simulated established patient, according to a rotating schedule.

H) The secret shopper survey must be completed within the quarterly time period it represents and data derived from calls made during this time frame will constitute the data that are reported for that quarter.

I) In **Section 1**, the Health Plan shall provide aggregate metrics that will be the same as those provided by all Health Plans and represent timely access standards for the Medicaid population as a whole.

J) In **Section 2**, the Health Plan shall provide the same aggregate metrics as in Section 1, filtered to data specific to the Health Plan. Given that the sample is not designed to produce data is representative at the Health Plan level for a given quarter, the Health Plan may aggregate data across quarters, up to four rolling quarters, while reporting Health Plan-specific metrics.

1. Metrics shall be limited to secret shopper calls where the caller identified as a member of the Health Plan.

2. In addition, the Health Plan shall also list any qualitative observations noted by the timely access contractor that reflect any concerning attitudes or behaviors on the part of the provider or provider staff. Qualitative observations should include any provider contracted by the Health Plan who was included in the survey, regardless of whether the secret shopper identified as a member of the Health Plan, and be limited to data collected during the report quarter.
3. The Health Plan shall provide any follow-up or action steps it intends to take based upon any concerning findings in the quantitative or qualitative results of the survey.

K) In **Section 3**, the Health Plan shall qualitatively evaluate any gaps in its provider network and describe its strategies to addressing or closing those gaps. This includes filling out the QI_TAR_NAAAR_Qual_Template that provides justification and corrective actions that are currently underway to address the KPI shortcomings.

406.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance in the Timely Access Report. A majority of the KPIs will be based on Appointment wait times.

1. KPIs based on Appointment wait times
 - a. Pediatric Primary Care – Urgent Care and PCP sick visits within 24 hours
 - b. Adult Primary Care - PCP sick visit within 72 hours
 - c. Behavioral Health– Adult or child behavioral health routine visit within 21 days
 - d. Primary Care- Adult or child PCP routine visit within 21 days
 - e. Visits with Specialists within 4 weeks
 - f. Emergency Services Facilities- Emergency medical Situations - Immediate care (twenty four (24) hours a day, seven (7) days a week)

2. Health Plan Responses to Unmet KPIs

- a. Health Plans accurately describe the unmet KPIs and mitigation measures undertaken to address these deficiencies for previous quarter.

REPORT 407: HOSPITAL CLOSURE REPORT

407.1 Introduction

- A) The purpose of this report is to monitor the effect of hospital closures on members and the Health Plan's procedure and contingency plans in the event of a hospital closure.

407.2 Applicable Contract and Health Plan Manual Sections

- A) Section 6.2 (Report Descriptions) Any time there has been a significant change in the Health Plan's operations that would affect adequate provider capacity and services. A significant change is defined as any of the following:
 - 1. A decrease in the total number of PCPs by more than five (5) percent per island. For the island of Hawaii, the Health Plan shall calculate this percentage separately for East Hawaii and West Hawaii;
 - a. A loss of providers in a specific specialty where another provider in that specialty is not available on the island;
 - b. A loss of a hospital; or iv. Enrollment of a new population.

407.3 Terms and Conditions

- A) N/A

407.4 Methodology

- A) **This report contains 2 sections.**
- B) In **Section 1**, the Health Plan will submit a member-level data file.
- C) In **Section 2**, the Health Plan will report on qualitative questions regarding alternative service delivery sites and protocol for maintaining care continuity for affected members.

407.5 Key Performance Indicators

- A) N/A

REPORT 501: ACCREDITATION STATUS

501.1 Introduction

- A) The purpose of this report is to monitor the Health Plan's compliance with licensing and accreditation requirements, including:
1. Continuous National Committee for Quality Assurance (NCQA) Health Plan Accreditation; and
 2. Licensure as a Health Plan in the State of Hawaii.

501.2 Applicable Contract and Health Plan Manual Sections

- A) Section 5.1.E (Accreditation) contains Health Plan accreditation requirements.
- B) General Condition 1.2.2 (Licensing and Accreditation), as amended by Section 14.3 (Licensing and Accreditation), states Health Plan licensure requirements.
- C) Section 6.2.A.4.1 (Accreditation Status Report) references the current report.

501.3 Terms and Definitions

- A) N/A

501.4 Methodology

- A) **This report is organized into two sections.** Section 1 covers the Health Plan's NCQA Accreditation and Section 2 covers the Health Plan's Licensure.
- B) **Section 1:** The Health Plan shall attest that it is currently accredited by NCQA as a Health Plan, with no open corrective action related to the standards and elements associated with its QI Program, and provide accreditation information requested by DHS. The Health Plan shall submit details on accreditation ratings for DHS review, including the Accreditation effective date and expiration date as well as the product. If expiration of accreditation is imminent, the Health Plan shall describe activities it is undertaking to pursue accreditation renewal prior to the expiration of the current accreditation, and its progress in achieving accreditation as required. The Health Plan shall also provide a synopsis of any issues that have arisen that may impede the accreditation process, including any items requiring corrective action by NCQA, and shall provide a summary of the steps it has taken to address the

required corrective action. The Health Plan shall also use this section to notify DHS of any changes to its accreditation status.

- C) **Section 2:** The Health Plan shall attest that it is currently properly licensed and in good standing as a Health Plan in the State of Hawaii. If expiration of licensure is imminent, the Health Plan shall describe activities to pursue licensure renewal prior to expiration of the current license, and its progress in achieving licensure as required. The Health Plan shall also synopsis of any issues that have arisen that may impede the licensure process.
- D) The Health Plan shall gather the following documents to complete this report, and upload these documents as attachments to the report:
1. NCQA Current Certificate of Accreditation;
 2. NCQA Accreditation Survey Report, and any other Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings;
 3. Current accreditation activities (e.g., scheduled audit date, scheduled NCQA submissions, etc.), if any;
 4. Health Plan internal mock audits
 5. Hawaii State Department of Commerce and Consumer Affairs (DCCA) License to operate as a Health Plan;
 6. DCCA Certificate of Good Standing; and
 7. Current licensure activities (if any).

501.5 Key Performance Indicators (KPIs)

- A) DHS shall use the following KPIs to evaluate Health Plan performance on the Accreditation Status Report.
1. Current Accreditation Status: NCQA Health Plan Accreditation status is current.
 2. Presence of one or more deficits, corrective actions, areas of weakness, or concerns in Accreditation or Licensing

3. NCQA Rating (Overall)
4. NCQA Rating (Consumer Satisfaction)
5. NCQA Rating (Prevention)
6. NCQA Rating (Treatment)
7. Additional NCQA or Other Distinctions, Accreditations, Certifications, or Deeming
8. Current Certificate of Good Standing (DCCA)
9. Current Licensure Status: Health Plan is currently licensed by DCCA to operate as a Health Plan in the State of Hawaii.

REPORT 502: HEALTH DISPARITIES

502.1 Introduction

A) The purpose of this report is to track the Health Plan's progress towards identifying health disparities among members and implementing strategies and interventions that target the most severe disparities, particularly in areas of preventative care, behavioral health, and complications after hospitalization. Specifically, this report will focus on Performance Metrics that are already gathered and reported by the Health Plan in four areas within which health disparities may exist:

1. Cancer screenings, including (1) Colorectal Cancer Screening and (2) Breast Cancer Screening;
2. Access to preventative pediatric care for children and adolescents, as measured by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participant Ratio;
3. Early intervention for mental illness and substance use, including Follow-Up After Hospitalization or ED Visit for Mental Illness or AOD Abuse or Dependence, (2) Engagement with AOD Abuse or Dependence Treatment, and (3) Depression Screening and Follow-up Plan; and
4. Plan All-Cause Readmissions

B) These Performance Metrics will be stratified by four specified groupings, including:

1. Race;
2. English as a Second Language (ESL);
3. Region; and
4. Serious Mental Illness (SMI).

502.2 Applicable Contract Sections

A) Section 5.1 (Quality) contains information about the Medicaid Managed Care Quality Strategy (also known as the DHS Quality Strategy), including the

SDOH Transformation Plan to address health disparities. Specifically, Section 5.1.B.1.e.10 describes the purpose of the Health Disparities Report as part of the Health Plan's overall QAPI requirements.

B) Section 6.2.E.4 (Quality) includes reporting on health disparities.

502.3 Terms and Definitions

A) N/A

502.4 Methodology

A) This report leverages performance measure data the Health Plan already analyzes and reports to DHS and/or its EQRO in other reports (specifically EPSDT Report and QAPI/Performance Measures reports).

B) To begin, the Health Plan shall gather the most recent year's Patient Level Data (PLD) File submitted that includes patient-level performance measure data on all Health Plan members; and the Health Plan's EPSDT report. Performance measures used in this report will be a subset of measures in these two reports. The intent of this report is to stratify these measures by four stratifying dimensions in order to identify disparities across populations within the selected measures.

C) Several measures shall use data in the PLD file, including:

1. Adults' Access to Preventive/Ambulatory Health Services (AAP; Total)
2. Breast Cancer Screening (BCS; Total)
3. Follow-Up After Hospitalization or ED Visit for Mental Illness or AOD Abuse or Dependence (30-Day, Total), which is a composite of three measures within the PLD file:
4. Follow-Up After ED Visit for Mental Illness (FUM; 30-Day, Total),
5. Follow-Up After ED Visit for AOD Abuse or Dependence (FUA; 30-Day, Total), and
6. Follow-Up After Hospitalization for Mental Illness (FUH; 30-Day, Total)
7. Initiation and Engagement of AOD Abuse or Dependence Treatment (IET;

Engagement, Total)

8. Plan All-Cause Readmissions, Percent Observed 30-Day Readmissions (PCR; Observed 30-Day Readmissions for PCR/Index Stays for PCR)

9. Screening for Depression and Follow-Up Plan (CDF), including rates in three age groups:

a. 12-17 years

b. 18-64 years

c. 65+ years

D) The EPSDT measure "Participant Screening Ratio" shall be calculated as follows: Total Eligibles Receiving at least one initial or periodic screen / Total Individuals Eligible for EDPST for 90 days

E) The Health Plan shall use the following data to derive the selected stratifications:

1. Race: Information on the member's race is provided to the Health Plan in the Health Plan's monthly 834 report, and may be found in Loop 2100A, Segment DMG, Element DMG05. The Health plan shall use the 834 file, PLD, and other data sources to capture the most complete and granular race/ethnicity data available. Reported race shall be consolidated into race groupings as noted below.

a. The Health Plan may use race data available to the Health Plan, if more accurate. To the extent, the member's "best" or "preferred" race should be used if multiple races are noted.

b. DHS may provide the Health Plan with a member-level extract that includes detailed race-ethnicity that is more granular than the groupings available in the Health Plan's 834 report to support reporting.

2. English as a Second Language (ESL): Information on the member's language spoken at home is provided to the Health Plan in the Health Plan's monthly 834 report, and may be found in Loop 2100A, Segment LUI, Element LUI02. Reported language spoken shall be consolidated into

ESL/non-ESL groupings as noted in the reference table document. If more up- to-date or comprehensive data is available to Health Plans, then they may use it.

3. Region: Information on the member's residential zip code is provided to the Health Plan in the Health Plan's monthly 834 report, and may be found in Loop 2100A, Segment N4, Element N403. For the Health Plan's convenience, data submitted via the PLD file additionally contains the same zip code information, and therefore, may be used as well. The Health Plan may also use a more updated zip code if available to the Health Plan. Reported residential zip code shall be consolidated into geographic groupings as noted below.
4. Serious Mental Illness (SMI): The Health Plan shall identify members who meet criteria for SMI as defined further below.
5. To group the stratification dimensions into appropriate categories, the Health Plan shall refer to "Reference Table.xlsx" in this report's subfolder in the "Report Reference Tables and Data Submission Forms" folder.
 - a. The "Race Def" tab crosswalks the values provided in the Health Plan's 834 files to the corresponding "Race Group". The Race Group shall be used to stratify members by race in this report.
 - b. The "Language Def" tab crosswalks the values provided in the Health Plan's 834 files to the corresponding "ESL Group." The ESL Group shall be used to stratify members into those who do and don't speak English as a second language at home.
 - c. The "Region Def" tab crosswalks the residential zip codes provided in the Health Plan's 834 files, or otherwise available to the Health Plan, to the corresponding "Region". The Region shall be used to stratify members by geographic communities for reporting.
 - d. The "SMI Def" tab provides various ICD-10 diagnostic codes to identify members with SMI. To comprehensively identify members with SMI, the Health Plan shall identify members with an SMI-related ICD-10 diagnosis (as provided in the "SMI Def" tab) during the 18 months prior to the start date of the reporting period. A member with one or more SMI diagnosis codes appearing anywhere

in a claim submitted to the Health Plan shall be included in this population. If a member has no claims available to assess SMI status, then they will be classified as “missing”.

- F) One measure (i.e. CDF) must be parsed by age group into three age groups: 12-17 years, 18-64 years, and 65+ years. The Health Plan shall parse members by age based on information available to the Health Plan.
- G) Once the member data has been parsed into the various dimensions, the Health Plan shall apply these dimensions to it’s PLD file and EPSDT reports to parse the measures selected for this report into the stratifications under each domain.
- H) One final derived variable that the Health Plan shall calculate for this report is “Follow-up After ED Visit or Hospitalization for Mental Illness or AOD Abuse or Dependence (30 Days)”, which is a composite of three measures:
 - 1. Follow-Up After Emergency Department Visit for AOD Abuse or Dependence (FUA): 30-Day Follow-Up—Total,
 - 2. Follow-Up After Hospitalization for Mental Illness (FUH): 30-Day Follow-Up—Total, and
 - 3. Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30-Day Follow-Up—Total.
- I) The Health Plan shall gather all members who are in the eligible population (i.e., denominator) for FUA, FUH, or FUM and use the following formula to calculate weighted mean percentage across all three measures for each member:
 - 1.
$$\frac{(FUA \text{ Numerator} + FUH \text{ Numerator} + FUM \text{ numerator})}{(FUA \text{ denominator} + FUH \text{ denominator} + FUM \text{ denominator})} * \frac{(FUA \text{ denominator} + FUH \text{ denominator} + FUM \text{ denominator})}{3}$$
 - 2. The Health Plan shall then calculate the average weighted mean percentage for each stratification where indicated in the data template. The following chart outlines the due dates, data source/reporting period, and the purpose.

Report Section	Due Date	Data Source/Reporting Period	Purpose
Section 1: Aggregate-Level Data File	10/31	Prior year quality measure PLDF and most recent CMS 416 submission.	The Health Plan shall submit data in an Aggregate-Level Data File once per year based on data from the prior year's quality measure PLDF and the most recent CMS-416 data. This data submission shall remain the same for subsequent reporting periods until the annual resubmission of Section 1 data the next year.
Section 2: Health Disparities Initiatives	10/31	These will be tracked prospectively starting 10/1 – 9/30 of prior reporting cycle.	The Health Plan shall review the data submitted in Section 1 to identify three potential areas of concerning disparities and answer the questions regarding the chosen disparities.
Section 3: Annual Review	10/31	10/1 – 9/30 of prior reporting cycle.	The Health Plan shall provide an annual review of the progress of the prior year. The Health Plan shall summarize and reflect on the implementation of the selected interventions, challenges the Health Plan encountered, changes it implemented to the interventions as applicable, and qualitative and quantitative progress it achieved in addressing and reducing the selected disparities throughout the year. Health Plans are encouraged to connect the prior year's review and learnings to the selected health disparities and chosen initiatives for the upcoming year. *Health Plans are <i>not</i> required to submit an annual reflection for the QAPI report, but may reference the HDR in the QAPI if desired.
Section 4: Quarterly Updates	1/31, 4/30, 7/31, 10/31	1/31: 10/1-12/31 4/30: 1/1-3/31 7/31: 4/1-6/30 10/31: 7/1-9/30	The Health Plan shall provide quarterly updates on the three potential areas of concerning disparities identified in Section 2. These updates do not require the submission of new data in Section 1.

J) **Section 1:** After data preparation is completed, the Health Plan shall complete the report template. Section 1 shall be completed by the Health Plan once per year when reporting on the third quarter of the calendar year (due date of 10/31). Once completed, the data shall remain the same for subsequent reporting periods until the subsequent annual revision to Section 1 data. The Health Plan shall submit Section 1 data in an Aggregate Level Data File.

1. In the embedded Excel document, the Health Plan shall enter numerical data into all applicable cells. Percentages shall be calculated automatically.
 2. The Health Plan shall report the count of all individuals who belong to the eligible population (i.e., denominator), and report the count of all individuals who met criteria (i.e., numerator).
 3. The PCR Measure reported here is based on the number of Observed Readmissions. The Health Plan shall report the count of individuals with index stays in the denominator, and the count of individuals with observed 30-day readmissions in the numerator.
 4. For the combined measure (FUM, FUH, and FUA), the Health Plan shall only report the mean weighted percentages.
 5. For "EPSDT Screening", the Health Plan shall refer to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Report 202) for instructions for obtaining the "Total Eligibles Who Should Receive at Least One Initial or Periodic Screen" and "Total Eligibles Receiving at Least One Initial or Periodic Screen" in order to calculate the "Participant Ratio".
 6. In the "Total" tab, the Health Plan shall enter data for all members that were eligible for each measure.
 7. In the "Race", "Language", "Region", and "SMI" tabs, the Health Plan shall enter data for all members that were eligible for each measure, stratified by the specified groupings.
- K) **Section 2:** Section 2 shall also be completed by the Health Plan once per year (due date of 10/31). These initiatives will be identified prospectively starting 10/1-9/30 of the prior reporting cycle, and reported on each quarter until the next annual cycle begins. After populating the data, the Health Plan shall complete the Health Disparities Initiatives questions, including: the identification of three health disparities with justification for selection, proposed evidence-based interventions to address selected disparities, and information about existing initiatives to identify and address health disparities.
1. The Health Plan shall review its own data across the selected dimensions

to identify three potential areas of concerning disparities.

2. Disparities may be chosen based on a combination of factors including the extent/magnitude of the disparity (for example, in terms of standard deviations away from the Health Plan average), the “actionability” of the disparity in terms of the types of evidence-based interventions that could be applied to decreasing the disparity, or the alignment of the disparity with the Health Plan’s existing efforts so that these efforts may be leveraged to address the disparities identified in this report.
3. The disparities may be specific to a single dimension/ stratification or broader in scope. For example, the Health Plan may identify disparities across several measures in a particular community, and propose a focused community-based intervention targeting multiple measures. Or the Health Plan may identify a disparity in a given measure across several geographically co-located communities and propose a multi- community intervention targeting a single measure.
4. The Health Plan must justify and explain the rationale for choosing the disparities it has chosen. The disparities selected shall become areas that the Health Plan addresses through proposed interventions for the next three quarters.
5. The Health Plan must conduct a root cause analysis for the reasons for the disparities, focused on developing actionable interventions. For example, if there is a disparity in being screened, is this because the providers of the members in the disparate group do not systematically screen the members, or is it because the members aren’t scheduling routine check-ups?
6. After selecting the disparities the Health Plan has decided to focus on, the Health Plan shall propose an evidence-based intervention to address the disparity, using the literature, and knowledge it has gained from prior Performance Improvement Projects on successful and unsuccessful strategies. The proposed interventions must be specific and ideally proven to work in the selected community/dimension and for the measure(s) the Health Plan will address.
7. The Health Plan shall additionally describe its method for evaluating its progress on address/eliminating the disparity on a quarterly basis. The

method shall propose metrics (process or outcome measures) that shall be tracked, and any qualitative data the Health Plan shall use to ensure that the interventions is being implemented as planned and achieved the desired result.

- L) The Health Plan shall also have the opportunity to describe other health disparities it has identified in its population, and any other initiatives in progress to address health disparities.
- M) **Section 3:** Section 3 shall be completed by the Health Plan once per year (due date of 10/31) when reporting on 10/1-9/30 of the prior reporting cycle. The Health Plan shall provide an annual review of the progress of the prior year. The Health Plan shall summarize and reflect on the implementation of the selected interventions, challenges the Health Plan encountered, changes it implemented to the interventions as applicable, and qualitative and quantitative progress it achieved in addressing and reducing the selected disparities throughout the year. Health Plans are encouraged to connect the prior year's review and learnings to the selected health disparities and chosen initiatives for the upcoming year.
- N) **Section 4:** Section 4 shall be completed by the Health Plan in each quarter, with quarterly due dates of 1/31, 4/30, 7/31, and 10/31. The Health Plan shall provide quarterly updates on the implementation of the intervention, challenges the Health Plan has encountered, changes it has implemented to the intervention as applicable, and qualitative and quantitative progress it has achieved in addressing and reducing the selected disparities.

502.5 Key Performance Indicators (KPIs)

- A) DHS shall use the following KPI to evaluate Health Plan performance on the Health Disparities Report.
 - 1. Identification and justification of first health disparity: The Health Plan identified and justified the selection of the first health disparity (only applies to quarter where disparities are selected)
 - 2. Identification and justification of second health disparity: The Health Plan identified and justified the selection of the second health disparity (only applies to quarter where disparities are selected)
 - 3. Identification and justification of third health disparity: The Health Plan

identified and justified the selection of the third health disparity (only applies to quarter where disparities are selected)

4. Plan has demonstrated through quantitative and qualitative reporting progress over the prior year in addressing identified health disparities.
5. Implementation of intervention and progress in reducing first disparity: The Health Plan's interventions to address the first health disparity are being implemented as planned, and the Health Plan's metrics show progress in reducing or eliminating the identified disparity (only applies to quarters where quarterly updates are provided).
6. Implementation of intervention and progress in reducing second disparity: The Health Plan's interventions to address the second health disparity are being implemented as planned, and the Health Plan's metrics show progress in reducing or eliminating the identified disparity (only applies to quarters where quarterly updates are provided).
7. Implementation of intervention and progress in reducing third disparity: The Health Plan's interventions to address the third health disparity are being implemented as planned, and the Health Plan's metrics show progress in reducing or eliminating the identified disparity (only applies to quarters where quarterly updates are provided).

REPORT 503: PERFORMANCE IMPROVEMENT PROJECTS

503.1 Introduction

- A) The purpose of this report is to evaluate and monitor the Health Plan's compliance, progress, and integration of Performance Improvement Projects (PIPs) toward improving healthcare delivery and quality.

503.2 Applicable Contract and Health Plan Manual Sections

- A) 2.6.A.171 (Definitions/Acronyms) defines PIP as a required activity per 42 CFR §438.330(a).
- B) 5.1.B.4 (Performance Improvement Projects) describes PIPs requirements, including reporting, per 42 CFR §438.330(d).

503.3 Terms and Definitions

- A) N/A

503.4 Methodology

- A) The Health Plan shall continue working on PIPs as specified and guided by the DHS EQRO. All PIP deliverables shall continue to be submitted as they are currently. Health Plans are not required to attach PIP worksheets and submissions to this report. The current report shall be prepared and submitted by the Health Plan to DHS in addition to all required PIP reporting activities.
- B) **Section I, Wide Scale Adoption of Prior PIPs (Annual Reporting Only), Section I shall be submitted once annually following the retirement of a PIP.**
 - 1. The Health Plan shall describe any lessons learned from planning, implementing, and evaluating the last PIP cycle. These include both identified successes and barriers that could impact future PIPs and ongoing operations.
 - 2. The Health Plan shall list any follow-up actions identified from the last PIP cycle which an emphasis on any related changes that the Health Plan made to its QAPI practices, clinical practice guidelines, and other policies. These follow-up actions could include those identified as a result of any lessons learned.

3. The Health Plan shall then list which of the follow-up actions identified above have been implemented. This will also include the scale at which they are being implemented and plans to scale up, if applicable.

C) **Section II, Current PIP Activities (Quarterly Reporting)**, the Health Plan shall report on its **current, active PIP activities** in quarterly submissions.

1. The Health Plan shall report on any feedback received from the EQRO during the current PIP cycle and how it addressed the feedback into its PIP activities.
2. The Health Plan shall identify the number of members and providers these follow-up actions are impacting. For baseline, the Health Plan shall report the number of members and providers impacted in the original PIP.
3. The Health Plan shall report if it has received any written or informal feedback from the EQRO on PIP activities in the past quarter.
4. If yes, the Health Plan shall describe the feedback and how it addressed/incorporated the feedback into current PIP activities.
5. The Health Plan shall also report the frequency at which it is submitting module-required worksheets and data to the EQRO in accordance to reporting deadlines.
6. The Health Plan shall describe how it is engaging with other Health Plans contracted by DHS to align PIP activities.

503.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance on the Performance Improvement Project Report.

1. Substantive Clinical and non-Clinical Impacts of Previous Cycle's PIP: The Health Plan will be assessed on the impact of previous cycle's PIP on Health Plan QAPI practices, clinical practice guidelines, policy, patients' health outcomes, and other larger scale systematic changes. In addition, the number of members and providers impacted will be assessed.
2. Responsiveness to EQRO feedback on PIP: The Health Plan will be assessed on their responsiveness to EQRO feedback on PIP activities such

as but not limited to adherence to recommendations on evidence-based practices, selection of measurable objectives, feasibility, etc.

3. Timeliness of data submissions: Whether the Health Plan is submitting all PIP deliverables to the EQRO as specified by the module reporting deadlines.

REPORT 504: QUALITY ASSURANCE & PROGRAM IMPROVEMENT

504.1 Introduction

- A) The purpose of this report is to evaluate and monitor the Health Plan's compliance, progress, and performance on their Quality Assessment and Program Improvement (QAPI) activities toward improving quality of healthcare.

504.2 Applicable Contract and Health Plan Manual Sections

- A) Section 2.6.197 (Definitions) defines QAPI per 42 CFR §438.330
- B) Section 5.1.B defines QAPI as a required activity per 42 CFR §438.330, and the QAPI Plan.
- C) Section 5.1.B.2 describes the QAPI plan that is required to be submitted regularly to DHS.
- D) Section 6.2.B.4 describes Quality reports, including the QAPI and Quality and Performance Measurement Reports.

504.3 Terms and Definitions

- A) N/A

504.4 Methodology

A) This report contains four sections:

1. Section 1 is dedicated to performance measure submissions.
2. Section 2 is the QAPI Activities and Progress Report
3. Section 3 captures a qualitative narrative on the Health Plan's QAPI
4. Section 4 collects information on any member or provider surveys completed by the Health Plan

B) Section 1: Performance Measures Submissions

1. The Health Plan shall continue to work with MQD's EQRO to submit all performance measure data, including aggregate metrics, patient-level

data (PLD) files, and cooperate with measure audits as requested by the EQRO.

2. The Health Plan shall attest in this report if it has successfully submitted all performance measures by the reporting deadline.
3. The Health Plan may also add any comments regarding the performance measures and/or submissions.

C) Section 2: QAPI Plan and Progress Report

1. The Health Plan shall complete the embedded worksheet titled "QAPI Workplan and Progress Report." This worksheet is structured based on the Hawaii Quality Strategy 2020 document and the seven quality program committees that will oversee the seventeen objectives of the DHS Quality Strategy:
 - a. Primary care and physical health: Objectives 1, 2, 3, and 4
 - b. Behavioral health: Objectives 5 and 6
 - c. Special Health Care Needs: Objectives 7 and 8
 - d. CIS+: Objective 10
 - e. SDOH, Access to Care, and VBP: Objectives 11, 14, 16, 17
 - f. Coordinated & Appropriate Care: Objectives 9 and 15
 - g. LTSS, including HCBS: Objectives 12 and 13
2. Each tab corresponds to one of these seven quality program areas.
3. Each tab contains specific quality objectives tied to that program area.
4. The Health Plan shall use this structure to report its QAPI activities, workplan/workplan updates, and progress reports for all its QAPI activities.
5. If the Health Plan is engaged in any Performance Improvement Projects (PIPs) specific to that quality program area, those will be entered into a separate table after other QAPI tables.

6. DHS understands that several activities may be cross-cutting. If a given Health Plan activity fits into multiple objectives, the Health Plan shall list it once within the primary quality objective under which it fits.
7. Please include all Quality assurance and Performance Improvement Activities in the QAPI. Tabs and sections should not be left blank. Please use the following conventions in place of blank cells:
 - a. N/A = Plan does not perform activities in this area
 - b. Refer to [Other Report] = Plan is performing activities, however, they are being reported in another location.
 - c. Activities were not performed during this period = No activities were performed.
8. In the tab titled "SDOH, Access to Care, VBP" the Health Plan may list any QAPI activities tied to its SDOH plan.
9. Under each objective, the Health Plan will describe the quality activity(ies) it has conducted during the past quarter in "Quality Activity Description". This shall include sufficient information around the activity, any adoption or adaption of evidence-based practices, and other relevant descriptive information.
10. In columns A-I, the Health Plan shall describe each QAPI activity. For each activity, the Health Plan shall provide the following:
11. In column C, the Health Plan shall describe any root cause analysis conducted that led to the selection of the quality activity reported. This also includes any contributing factors, identification of key populations targeted by the activity, and identification of evidence-based practices for the activity. Health Plans shall also include the reasons why the Health Plan is working on this activity (e.g. findings from compliance review, CAP, quality program, etc).
12. The Health Plan shall list key Health Plan Personnel leading and involved with the activity in column D. This includes name and position.
13. The Health Plan shall describe the scale of the activity in column E. Some examples include an activity that is only being conducted at a hospital, an

independent physician's association (IPA), or even group of providers in a geographic region.

14. The Health Plan shall report the exact or estimated number of members impacted by this activity in column F. The number of members impacted shall be related to the scale of the activity.
15. In column G, the Health Plan shall list any partners contributing to the activity.
16. In columns H and I the Health Plan shall report the month and year that the activity started and anticipated end date, if any.
17. Unless activities are updated, once this section has been completed, these columns may remain static while the Health Plan reports on quarterly progress updates and data on each activity.
18. In Columns J-N, the Health Plan shall report on the Progress of each QAPI Activity.
19. Under the Progress Reporting section, the Health Plan shall report the current status of the activity at time of submission (column J).
 - a. Limit options to: "In progress", "Completed", "Paused", or "Abandoned".
20. In Column K, the Health Plan may submit any barriers they are encountering while conducting the activity such as policy-related barriers.
21. The Health Plan shall also describe their progress on the activity during the previous quarter in column L.
22. In Columns M-AM, the Health Plan shall collect and report on data used to track progress on the activity over the contract period unless the activity is completed or abandoned.
23. The Health Plan will be required to use performance measures to monitor the impact of their activity. A performance measure can be a clinical quality measure such as HEDIS or validated/evidence-based performance measures from other data sources. The name of the measure will be reported in column M and a description of the data source in column N.

24. The Health Plan will be required to report out performance measure data at various stages during a quality activity's implementation stage.

- a. First, baseline data for which the reporting period will be at the start or before the activity begins implementation, will be reported in Columns O-R.
- b. The reporting period of the data will be entered in column O.
- c. Depending on the data source used, the numerator, or if the measure is just a count, will be reported in column P.
- d. Any denominator of the measure shall be reported in column Q.
- e. Finally, if both denominator and numerator are reported then a rate/percent shall be calculated which is the numerator divided by the denominator multiplied by 100.
- f. For each contract year, the Health Plan shall determine a performance measure target for the activity (e.g. Columns S- V) and provide any applicable numerator, denominator, and rate calculations.
- g. The Health Plan shall then report performance measure data quarterly to monitor their progress toward reaching the year 1 target. The first quarter (Columns W-Z) will represent any change in the measure during that reporting period.
- h. Subsequent quarter submissions will reflect data cumulative since the start of the activity. For example, quarter 2 performance measure data (Columns AA-AD) will reflect data from quarters 1 and 2 combined.
- i. The Health Plan may include any performance measure notes in column AM.

25. The Health Plan shall list any PIPs they are conducting in the section labeled "Performance Improvement Projects" for any given quality strategy area (i.e. per tab in the worksheet). The same structure used for reporting on QAPI activities shall also be used to report on PIP progress.

26. The Health Plan shall progressively complete the template for each contract year. The prior reporting period's data shall be maintained, while the Health Plan adds the new reporting period's data.
27. The last two tabs of the document shall focus on Access to Care and Structure and Operation Standards. Any QAPI activities reported here shall follow the same format as previously described; however, the first column shall list the specific category of the standards within which the activity falls. Each of the columns described above is shifted to the right by one column.

D) Section 3: QAPI Qualitative Narrative

1. The Health Plan will respond to a series of questions in the report template, and provide an executive summary of its QAPI program.

E) Section 4: Provider or Enrollee Satisfaction Survey

1. If the Health Plan completed any provider or enrollee satisfaction survey during the reporting period, including but not limited to any CAHPS® Consumer Surveys, the Health Plan shall respond "yes" to the question in Section 4, and attach both the survey and survey results.

504.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance on the QAPI Report.

1. HEDIS Measure Submissions: The Health Plan will be assessed on the timeliness of HEDIS Data Submission.
2. Robust QAPI plan/progress report for Primary Care and Physical Health: The Health Plan's QAPI activities, scale, progress report, performance measurement, indicate a robust and effective approach likely to improve the delivery and quality of Primary Care and Physical Health services to the member population, in alignment with the goals of the State Quality Strategy.
3. Robust QAPI plan/progress report for Behavioral Health: The Health Plan's QAPI activities, scale, progress report, performance measurement, indicate a robust and effective approach likely to improve the delivery and

quality of Behavioral Health services to the member population, in alignment with the goals of the State Quality Strategy.

4. Robust QAPI plan/progress report for Special Health Care Needs: The Health Plan's QAPI activities, scale, progress report, performance measurement, indicate a robust and effective approach likely to improve the delivery and quality of Special Health Care Needs services to the SHCN member population, in alignment with the goals of the State Quality Strategy.
5. Robust QAPI plan/progress report for Community Integration Services Plus (CIS+): The Health Plan's QAPI activities, scale, progress report, performance measurement, indicate a robust and effective approach likely to improve the delivery and quality of Community Integration Services to the CIS+ member population, in alignment with the goals of the State Quality Strategy.
6. Robust QAPI plan/progress report for Social Determinants of Health, Access to Care, and Value-Based Purchasing: The Health Plan's QAPI activities, scale, progress report, performance measurement, indicate a robust and effective approach likely to improve the Health Plan to address and mitigate SDOH-based disparities in the member population, improve access to care across various healthcare settings, and enhance adoption of more advanced VBP and APM models by providers, in alignment with the goals of the State Quality Strategy.
7. Robust QAPI plan/progress report for Coordinated and Appropriate Care: The Health Plan's QAPI activities, scale, progress report, performance measurement, indicate a robust and effective approach likely to improve the delivery and quality of coordinated and appropriate care to the member population, in alignment with the goals of the State Quality Strategy.
8. Robust QAPI plan/progress report for Long-Term Services and Supports: The Health Plan's QAPI activities, scale, progress report, performance measurement, indicate a robust and effective approach likely to improve the delivery and quality of
9. LTSS, including but not limited to the assurance of HCBS settings requirements, to the LTSS member population, in alignment with the

goals of the State Quality Strategy.

10. Robust QAPI plan/progress report for Access to Care Standards: The Health Plan's QAPI activities, scale, progress report, performance measurement, indicate a robust and effective approach to assure Access to Care Standards for the member population, in alignment with the goals of the State Quality Strategy.
11. Robust QAPI plan/progress report for Structure and Operations Standards: The Health Plan's QAPI activities, scale, progress report, performance measurement, indicate a robust and effective approach to assure Structure and Operations Standards for the member population, in alignment with the goals of the State Quality Strategy.
12. Consideration of Special Populations, Primary Care and Physical Health: The Health Plan's QAPI activities, scale, progress report, performance measurement tied to Primary Care and Physical Health, indicate a robust and effective approach to assure special considerations for LTSS, CIS+, and SHCN members, in alignment with the goals of the State Quality Strategy.
13. Consideration of Special Populations, Behavioral Health: The Health Plan's QAPI activities, scale, progress report, performance measurement tied to Behavioral Health, indicate a robust and effective approach to assure special considerations for LTSS, CIS+, and SHCN members, in alignment with the goals of the State Quality Strategy.
14. Consideration of Special Populations for SDOH, Access to Care, and VBP: The Health Plan's QAPI activities, scale, progress report, performance measurement tied to addressing SDOH, improving Access to Care, and advancing VBP, indicate a robust and effective approach to assure special considerations for LTSS, CIS+, and SHCN members, in alignment with the goals of the State Quality Strategy.
15. Consideration of Special Populations, Coordinated and Appropriate Care: The Health Plan's QAPI activities, scale, progress report, performance measurement tied to Coordinated and Appropriate Care, indicate a robust and effective approach to assure special considerations for LTSS, CIS+, and SHCN members, in alignment with the goals of the State Quality Strategy.

16. Consideration of Special Populations, Access to Care Standards: The Health Plan's quality assurance activities, scale, progress report, performance measurement tied to Access to Care Standards, indicate a robust and effective approach to assure special considerations for LTSS, CIS+, and SHCN members, in alignment with the goals of the State Quality Strategy.
17. Consideration of Special Populations, Structure and Operations Standards: The Health Plan's quality assurance activities, scale, progress report, performance measurement tied to Structure and Operations Standards, indicate a robust and effective approach to assure special considerations for LTSS, CIS+, and SHCN members, in alignment with the goals of the State Quality Strategy.
18. Health Plan Issuance of Evidence-Based Practice Guidelines: The Health Plan has issued evidence-based practice guidelines on topics that align with the goals of the State Quality Strategy.
19. Health Plan Evaluation of Issued Practice Guidelines: The Health Plan has a robust plan to evaluate the effectiveness and impact of issued practice guidelines.

REPORT 505: ADVERSE EVENTS

505.1 Introduction

- A) The purpose of the Adverse Events Report is to 1) monitor key adverse events related to medical care or institutional care and level of harm members experience due to such events each quarter, and 2) the Health Plan's resulting response and mitigation strategy(ies). This report will consolidate adverse events reporting for various special populations including LTSS, HCBS, SHCN, EHCN, and CIS+. It is understood that health plans may not have access to adverse event reports from skilled nursing facilities (SNF).
- B) Health Plans shall report all adverse events related to medical or residential care, regardless of the level of harm incurred. This includes events categorized as resulting in no harm (Categories A–D), as these data points are critical for identifying patterns and trends across member populations, care settings, and adverse event types.

505.2 Applicable Contract and Health Plan Manual Sections

- A) Section 6.2.E (Home and Community Based Services Report) states the requirements tied to adverse event reporting systems for HCBS and report submission.

505.3 Terms and Definitions

- A) **Adverse Event:** An event, preventable or nonpreventable, that caused harm to a patient as a result of medical care, residential care, or resulted from provider preventable conditions or healthcare acquired conditions. In the current report, all adverse events shall be reported as events that were related to medical care, or residential care. Types of adverse events include; medication-related, Treatment-related, Neglect, Abuse, Suicide/ Suicide Attempt, Exploitation, Fall/Fall-related Injury, Elopement/Missing Person, Restraint/Seclusion, Insect Infestation, Healthcare Acquired Infections (HAI), Healthcare Acquired Conditions (HAC), and other.
- B) **Adverse Events Related to Medical Care:** Adverse events related to medical care may occur in any setting including in an institution or while the member is receiving residential care, at the member's home, or elsewhere. All such incidents must be gathered and reported by the Health Plan. Health plans

shall report adverse events related to medical care even upon discharge; there is no time frame upon which adverse events are not to be reported. If the health plan is unsure of whether or not an adverse event post-discharge was related to medical care, a root cause analysis must be completed.

- C) **Adverse Events Related to Residential Care:** Adverse events may result while the member is in institutional or residential care. Specifically, these types of adverse events are reportable if they occur in any types of institutional/residential care settings for which the Health Plan pays, or if they occur while the member is under the care of a provider for which the Health Plan pays. In other words, if a member experiences abuse while hospitalized, or under the care of a private duty nurse in their home, then the event is reportable. However, if a member experiences an adverse event at home that is not related to their healthcare, then the event is not reportable as an adverse event for the purposes of this report.
- D) **Events Related to Infection:** These will be operationally defined as Healthcare Associated Infections (HAIs). These include infections that members experienced while receiving surgical or other medical treatment or services. A defined list of HAIs can be found here: <https://cdc.gov/hai/infectiontypes.html>.
- E) **Cascade Events:** A “cascade event” is defined as an event that included a series of multiple, related adverse events. Cascade adverse events are common in the Medicaid population. Where cascade events are noted, they shall typically be grouped as one event in the category that is most closely associated with the cause of the adverse event. For example, if a medication error resulted in an adverse drug event, then the events in the cascade shall be grouped into medication error and classified under “Other Provider Preventable Conditions” for the purpose of this report. If a cascade event includes distinctly different types of adverse events where the occurrence of one event did not cause the next event in the cascade (e.g. a case where a member was exploited and later abused), these shall be reported as distinct adverse events.
- F) **Harm:** Harm shall be assessed using a method adapted from the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Index.

1. Harm may be categorized from Category A-I based on the table below.

2. Harms associated with categories E-I are required to be reported, and must follow the definition of an adverse event above.
3. Events in category E shall be reported as adverse events resulting in temporary patient harm, but not causing death.
4. Events in categories F-H shall be reported as adverse events resulting in permanent patient harm, but not causing death.
5. Events in Category I shall be reported as adverse events resulting in death.

Category	Description	Harm Categorization
Category A	Circumstances that have the capacity to cause an adverse event.	Unsafe condition or near miss
Category B	An event occurred that did not reach the patient (an "error of omission" does reach the patient).	
Category C	An event occurred that reached the patient but did not cause patient harm. Harm is defined as "any physical injury or damage to the health of a person requiring additional medical care, including both temporary and permanent injury."	Adverse event, no harm
Category D	An event occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm. Monitoring is defined as "to observe or record physiological or psychological signs." Intervention is defined as including "change in therapy or active medical/surgical treatment."	Adverse event, no harm, increased patient monitoring needed
Category E	An event occurred that may have contributed to or resulted in temporary harm to the patient but did not require a significant intervention. Significant intervention is defined as "an intervention intended to relieve symptoms that have the potential to be life-threatening if not addressed."	Adverse event, less serious harm
Category F	An event occurred that may have contributed to or resulted in temporary harm to the patient and required a significant intervention. Significant intervention is defined as "an intervention intended to relieve symptoms that have the potential to be life-threatening if not addressed." The types of interventions may include, but not be limited to, an emergency visit, hospitalization, or prolongation of an existing hospitalization or institutional stay.	

Category G	An event occurred that may have contributed to or resulted in permanent patient harm. Permanent harm is defined as "harm lasting more than 6 months, or where end harm is not known ('watchful waiting')."	Adverse event, serious harm or death
Category H	An event occurred that required intervention necessary to sustain life. Intervention necessary to sustain life is defined as including "cardiovascular and/or respiratory support (e.g., CPR, defibrillation, intubation)."	
Category I	An event occurred that may have contributed to or resulted in patient's death.	

Adapted from "NCC MERP Index for Categorizing Medication Errors." 2001 National Coordinating Council for Medication Error Reporting and Prevention.

505.4 Methodology

A) **This report is organized into three sections.**

B) In **Section I: Member-level Adverse Event Data File**, the Health Plan shall report on member-level adverse events whose cases were resolved in the reporting period, including adverse events that occurred either during or prior to the reporting period.

1. Only adverse events that were experienced by a member shall be reported; adverse events inflicted by the member shall not be included. As an example, if one member abuses another member in a residential care setting, the abused member is said to have experienced the adverse event that resulted.
2. To properly format the data file, the Health Plan shall refer to "AER_MLDF_DataFormat.xlsx" in this report's subfolder within the "Report Reference Files and Data Submission File" folder.
3. Each row corresponds to a single adverse event experienced by a specific member. If an adverse affected multiple members, then each member will represent a separate row. Additionally, if a member experienced multiple adverse events during a reporting period, then separate rows shall be used to report each adverse event.
4. The member's Medicaid ID must be reported under "HAWI_ID."
5. The Health Plan shall report whether the member is enrolled in LTSS,

SHCN, GHP, EHCN or CIS+ at the time of the adverse event as specified in the data file format. If a member has multiple adverse events reported in the reporting period, then the designations must reflect their status at that time. If a member is enrolled in multiple programs at the time of the event, the health plan shall report each of the programs.

6. The type of adverse event shall be reported under "AE_type." The classifications are listed under the data format file but include adverse events related to medical care, residential care, and infections.
7. A description of the adverse event shall be reported under AE_Description. The description must include, at minimum, when the event occurred, what the event comprised of, who was involved in the event, and how the member was impacted.
8. The severity level of the adverse event shall be reported under "Harm_Level." The categories include "Unsafe condition or near miss," "no harm," "harm," and "death." The final harm level shall be classified.
9. The Health Plan shall report if a root cause analysis was performed "Root_Cause_Analysis_CCMA" and/or "Root_Cause_Analysis_HP" to identify any precipitating and contributing factors related to the adverse event. Any adverse events that the Health Plan believes fall into a grey area, making it difficult to discern whether the adverse event was related to medical or residential care, must have a root cause analysis performed by the Health Plan in order to determine the root cause of the event and whether it should be reported as an adverse event related to medical or residential care. Upon completion of a root cause analysis, the Health Plan must identify the contributing factors under "Contributing Factors." Health Plans are invited to use their own root cause analysis protocols.
10. If a similar adverse event occurred in the same setting (exact same location) within the previous 12 months up to submission of the report, then the Health Plan shall report "Yes" under "Similar_AE_Setting_HP."
11. If a similar adverse event occurred to the same individual within the previous 12 months up to submission of the report, then the Health Plan shall report "Yes" under "Similar_AE_Member_HP."
12. The Health Plan shall describe any action steps identified as a result of

the adverse events in "Action_Steps."

13. The setting in which the adverse event occurred shall be listed under "Setting_Name." If the setting occurred at a provider's office, then list the provider's name.
14. The Provider's Med-QUEST ID shall be reported under "MQD_Provider_ID." If provider does not have a Med-QUEST ID, then enter "N/A"
15. The Health Plan shall attest if a site visit was conducted at the setting the adverse event occurred as a result of the adverse event under "Site_Visit."
16. If a Site Visit occurred, the Health Plan shall list the date of the site visit under "Site_Visit_Date".
17. If a Site Visit occurred, the Health Plan shall describe any recommendations or action steps that precipitated as a result of the site visit.
18. In "Mitigating_Factors_Implemented," the Health Plan shall report if recommendations, action steps, and/or mitigating factors have been implemented as a result of the adverse event. If yes, then the Health Plan shall describe which were implemented "Describe_Mitigating_Factors_Imp".

C) In **Section II: Aggregate-level Adverse Event Data File**, the Health Plan shall report on aggregate and summary adverse events experienced by members that were identified in the past quarter. The first tab corresponds to a deduplicated table of adverse events experienced by the Health Plan's members across all populations. Each subsequent tab on the worksheet corresponds to a specific group. If a member is enrolled in multiple programs (e.g., SHCN and LTSS) then the adverse events the member has experienced shall be noted in both tabs. However, the member's adverse events must be reported only once in the first tab that includes de-duplicated counts.

1. Health Plan shall then report the following by adverse event type, parsed by events that occurred during the reporting period and events that were identified during the reporting period but occurred during a previous

reporting period:

2. Number of events identified (All events) that resulted in any harm.
3. In Row 20 for "Total # Members in Reporting Period", at the bottom of the spreadsheet the Health Plan shall provide data on the total number of members covered.
4. In Row 21 for "Number of Members with Two or More Adverse Events in the 12 months Prior to the Last Day of the Reporting Period", the Health Plan shall also report the number of members who experienced two or more adverse events related to their healthcare in the 12 months prior to the last day of the reporting period in any category of adverse events."

D) In **Section III: Adverse Events Reporting System**, the Health Plan shall respond to a series of qualitative questions about its Adverse Events Reporting System.

505.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. Percent of members (Deduplicated, LTSS-Nursing Home, LTSS- At Risk, LTSS-Sub-acute/Waitlist, LTSS-HCBS, CIS+, SHCN, GHP Other) with two or more adverse events in past year. (8 KPIs in Total)
2. Percent of adverse events reported to the Health Plan within 72 hours (Total – Deduplicated)
3. Health Plan has an adequate system or policies and procedures to retrospectively identify adverse events experienced by members.
4. If action steps were taken, were they appropriate to safeguard the member?

REPORT 601: PRIMARY CARE

601.1 Introduction

- A) The purpose of this report is to track progress towards the Health Plan's investments in Primary Care through the following definitions:
1. Primary Care Visits, which are the setting for preventive care provided by primary care providers, often serving as the first point of care for an individual.
 2. Primary Care Services, or services provided or, in some cases, recommended in the outpatient primary care setting. Primary Care Services are parsed into:
 3. Beneficial Primary Care Services, defined as preventive care with a focus on high value care services such as screenings, immunizations and vaccinations provided in the primary care setting; and
 4. Low Value Primary Care Services, defined as services that are typically considered unnecessary and known to result in wasteful spending.
 5. Primary Care Supports, defined broadly as the set of care services that engage, support, stabilize, and improve management of the member in the outpatient setting, so as to reduce excessive and inappropriate inpatient utilization.
- B) This report will collect data on the Health Plan's implementation of, and spending on, the PCP Enhancement (PCP-E) Program.
- C) Additionally, this report will gather information on Primary Care Provider Attribution, defined as the formal designation of providers to members to provide primary care.
1. Member Attribution must be conducted on a quarterly basis. Within an annual report, a member must not be attributed to a new provider more than once every 3 months.

601.2 Applicable Contract Sections

- A) Section 3.2.E (Advancing Primary Care (APC)) contains information about support provided to practices that are interested in advancing primary care

models.

- B) Section 6.2.E.5 (Report Descriptions – Utilization) references the Primary Care Report.
- C) Section 7.2.C (Provider and Subcontractor Reimbursement) references the Health Plan’s requirement to make payments to providers and its Subcontracts subject to any directed payment policies implemented by DHS; the PCP Enhancement (PCP-E) payment program is a directed payment policy.
- D) Section 7.2.E (Investing in Primary Care) describes the strategic approach to increasing investment in Primary Care, and aligns directly with the intent of this report.
- E) Section 8.1.E (Primary Care Providers) contains information about procedures for formally attributing members to primary care providers to members.

601.3 Terms and Definitions

- A) **Primary Care Visits:** Member visits, typically for the provision of evaluation and management services, to primary care providers in the outpatient setting.
- B) **Beneficial Primary Care (BPC) Services:** Services of proven value and with no significant tradeoffs. The benefits of these services outweigh the risks that all patients with specific medical conditions should receive them. BPC Services focus on preventative care that provide substantial individual, community, and population health benefits.
- C) **Low Value Primary Care (LVPC) Services:** Patient care that offers little to no net clinical benefit, and which can lead to patient harm and unnecessary spending on wasteful services. LVPC can harm patients directly by placing them at risk from unnecessary testing and procedures, or also by diverting resources away from BPC or services that have net health benefits. LVPC include treatments, tests, and procedures that have been shown in the medical community and previous research to provide little benefit to patient care and health.
- D) **Primary Care Supports:** Services such as care coordination, multi-disciplinary team-based care, outpatient mental health services, and medication therapy management, that in combination support primary care services delivered in the primary care setting, and improve the overall

management of the member in the outpatient setting.

- E) **Total Medical Spend:** The sum of 438.3(e)(2) Incurred Claims and 438.8(e)(3) Quality Improvement Expenses used to calculate the numerator of the Medical Loss Ratio (MLR) in the Health Plan's most recently completed MLR report shall serve as the "Total Medical Spend" in this report.
- F) **PCP Enhancement (PCP-E) Payment:** PCP Enhancement is intended to reimburse PCP services at the prevailing Medicare rate. The targeted providers include providers and subspecialists of family medicine, internal medicine, pediatric medicine, geriatric medicine, preventive medicine, and general practice (i.e. Primary Care Providers); and obstetrics and gynecology (Ob/Gyn providers). Both existing and established providers as well as providers brand new to the Hawaii Medicaid market may be eligible for PCP enhanced reimbursements. The program is expected to expand to include Nurse Practice Nurses and Physician Assistants beginning with CY2022.

601.4 Methodology

A) This report is organized into three sections.

1. In Section 1, the Health Plan shall calculate and report its investment in primary care in support of the APC Initiative as specified using various definitions; and its total spend in the PCP-E Program, parsed by provider type.
2. In Section 2, the Health Plan shall answer a series of questions intended to better understand the Health Plan's methodologies used across both programs. In Section 3, the Health Plan shall provide a Member Attribution and Assignment File that attributes its members to all providers serving as the member's Primary Care Providers.
3. Instructions on calculating Advancing Primary Care (APC) costs:
 - a. All calculated costs shall include both actual and incurred costs. Incurred claims should reflect total paid and incurred claims with claims run-out through six (6) months after the end of the reporting period.
 - b. Since costs are calculated by HCPCS or CPT codes, the Health Plan shall generally include only line-level costs specific to the included

HCPCS or CPT codes. Claim-level costs may be included only for procedures where the procedure cannot be performed without additional costs included in the claim. For example, a colonoscopy may not be performed without the corresponding anesthesia, therefore these costs may be aggregated; however, the pre-operative consultation visit may not be included in the cost of performing a colonoscopy.

- c. If the Health Plan supported enhancements in primary care through quality bonuses, or by investing in quality improvement across any of the Primary Care spend categories, the Health Plan may include this spend in its calculation, and develop a justifiable method to identify and allocate the spending across Primary Care definitions and populations; generally, unless quality or bonus payments were paid simply to ensure access to care, it is expected that quality payments will predominantly be included in Definitions 2a, 2b, or 3.
 - d. The Health Plan shall ensure that all costs reported in this report are subsets of costs that the Health Plan also reports under 438.8(e)(2) Incurred Claims and 438.8(e)(3) Activities that improve health care quality in the MLR Report. Cost exclusions that apply to the MLR report shall also apply to the current report.
 - e. If line-level HCPCS or CPT codes cannot be parsed (e.g. for bundled services), or in the case of sub-capitation claims, the Health Plan shall use a Medicaid “valued” amount (e.g. the Health Plan’s fee schedule) for that HCPCS or CPT code to parse costs.
- B) To complete Section 1, the Health Plan shall refer to “PCR Reference Tables and Data Submission Format” in the report’s subfolder within the “Report Reference Tables and Data Submission Formats” folder.
- C) **Section 1, Tab 1 (Aggregate Metrics – APC)**, the Health Plan shall calculate and report spend across multiple, mutually exclusive definitions of “Primary Care Spend.”
- 1. Primary Care Definition 1 (Primary Care Visits) is loosely based on a report developed by Milbank Association that looks at primary care spend as a function of primary care visits to primary care providers. Spend is quantified as the total reimbursement for these visits, or where specific

compensation was not provided, the volume of visits times the valued rates for these visits. To calculate spend based on Primary Care Definition 1 (Primary Care Visits), the Health Plan shall complete the following steps:

- a. Filter claims to services rendered by Primary Care Providers only, as identified using the "APC Providers" tab. The Health Plan shall use the servicing provider information to complete this step.
 - b. Filter claim lines rendered by primary care providers to those service costs identified under Definition 1 (Def_1), Primary Care Visits, in the "APC Services" tab. Use the column titled "Category" to parse primary care visits into the categories associated with Definition 1.
 - c. Parse spend into four population groups in alignment with actuarial definitions: ABD (Medicaid Only); ABD (Medicaid and Medicare Dual); Family and Children; and Expansion.
2. Primary Care Definition 2a (Beneficial Primary Care (BPC) Services) is loosely based on prioritized clinical preventive services, that are grouped into several major categories. Spend is quantified as the total reimbursement for these services, or where specific compensation was not provided, the volume of services times the valued rates for these services. To calculate spend based on Primary Care Definition 2 (BPC Services), the Health Plan shall complete the following steps:
 - a. Filter claim lines to those service costs identified under Definition 2a (Def_2a), BPC Services, in the "APC Services" tab. Use the column titled "Category" to parse BPC claim lines into the categories associated with Definition 2; no filtering based on the servicing provider is needed.
 - b. Parse spend into four population groups in alignment with actuarial definitions: ABD (Medicaid Only); ABD (Medicaid and Medicare Dual); Family and Children; and Expansion.
3. Primary Care Definition 2b (Low Value Primary Care (LVPC) Services) is based on select Low Value Care services, as defined by the Milliman MedInsight Health Waste Calculator methodology.

- a. The Health Plan shall calculate its potentially wasteful health spending for the following measures at the claim line level:
 - 1) APA01 - Two or more antipsychotic medications
 - 2) AAP00 - Pediatric Head Computed Tomography Scans
 - 3) AFP05 - Annual Resting EKGs
 - 4) AAPMR05 - Opiates in acute disabling low back pain
 - 5) AP00 - Antibiotics for Acute Upper Respiratory and Ear Infections
 - b. These measures were chosen based upon their relative impact on the QUEST member population.
 - c. The methods to calculate these measures are available from the Med-QUEST Actuary. In order to receive access to the methods, the Health Plan shall refer and sign the "Notice and Access Agreement-HWC Measures (2.26.21)" in this report's folder within the "Report Reference Tables and Data Submission Files" folder. The methods shall be subsequently released to the Health Plan.
 - 1) If the Health Plan does not sign the agreement, the measures shall be calculated at a cost to the Health Plan for the Health Plan by the DHS Actuary.
 - d. The Health Plan shall follow the methods specified by the Med-QUEST Actuary to calculate spend for the five measures selected above.
 - e. The Health Plan shall parse spend into four population groups in alignment with actuarial definitions: ABD (Medicaid Only); ABD (Medicaid and Medicare Dual); Family and Children; and Expansion.
4. Primary Care Definition 3 (Primary Care Supports) intends to identify services that support and augment primary care services. To calculate spend based on Primary Care Definition 3 (Primary Care Supports), the Health Plan shall complete the following steps:
- a. Filter claim lines to those service costs identified under Definition 3

(Def_3), Primary Care Supports, in the "APC Services" tab. Use the column titled "Category" to parse Primary Care Support claim lines into the categories associated with Definition 3; no filtering based on the servicing provider is needed.

- b. Parse spend into four population groups in alignment with actuarial definitions: ABD (Medicaid Only); ABD (Medicaid and Medicare Dual); Family and Children; and Expansion.

- 5. The 'Total Spend' shall be the same as the field that serves as the numerator of the Medical Loss Ratio calculation in the MLR report. The Health Plan shall use the numerator of the most recent MLR report completed by the Health Plan.

D) **Section 1, tab 2 (Aggregate Metrics – PCPE)**, the Health Plan shall calculate and report on its PCP Enhancement spending, parsed by major provider category.

- 1. Under "Total Number of Servicing Providers," the Health Plan shall provide a count of the total number of servicing providers it was contracted with during the reporting period that were eligible for the PCP-E payment. In order to group providers into the descriptions provided, the Health Plan shall refer to the "PCPE Providers" tab in the "PCR Reference Tables and Data Submission Format" document.
- 2. Based on services rendered during the reporting period, the Health Plan shall identify the subset of servicing providers who were eligible to receive any PCP-E payments during the reporting period. Services eligible for PCP-E payments are provided in the "PCPE Services" tab in the "PCR Reference Tables and Data Submission Format" document.
- 3. The Health Plan shall calculate or estimate the amounts owed to the eligible providers in the absence of the PCP-E program and report these under the "Amounts Owed Based on Medicaid Payment Schedule."
- 4. The Health Plan shall then report the actual amounts paid to the eligible providers given the PCP-E program. The PCP-E payments made will be automatically calculated.

E) In **Section 2**, the Health Plan shall respond to a series of qualitative questions

about the methodologies used for APC and PCPE reporting and other information to contextualize the data submitted.

F) In **Section 3**, the Health Plan shall submit a Primary Care Provider Member Attribution and Assignment Table (PCPMAAT) annually.

1. The format of the PCPMAAT is provided in the report template, including data fields. Please additionally refer to the "PCPMAAT Submission Format" tab within the "PCR Reference Tables and Data Submission Format" document.
2. General variables in the dataset that are not particular to this report are to be reported as defined by the "Health Plan Provider Network (HPS) File" in the HPMMIS Health Plan Provider Technical Guide.
3. Data should be reported at the level of each individual member of the Health Plan.
4. The member's Medicaid ID must be reported under "HAWI ID."
5. The "Member Attribution Begin Date" is the start date of the primary care attribution for that member with a given provider.
6. The "Member Attribution End Date" is the end date of the primary care attribution for that member with a given provider.
7. If the member is attributed to multiple primary care providers within the given reporting period, the Health Plan shall include the member in multiple rows to reflect all of the member's attribution(s) to primary care providers.
8. If while a member is attributed or assigned to a provider, the provider switches their physician organization affiliation, there should be multiple lines for a given member.
9. If the member has discontinuous segments in a given reporting period when the member was attributed to a given provider, the Health Plan shall include multiple rows to reflect each of the attribution segments.
10. The "Member Assignment Begin Date" is the start date of the primary care assignment for that member with a given provider.

11. The "Member Assignment End Date" is the end date of the primary care assignment for that member with a given provider.
12. The PCPMAAT shall include all physicians that a member seeks primary care from over the reporting period. At a minimum, the file shall include all applicable member x provider combinations for:
 - a. Any primary care providers whom the member is assigned;
 - b. Any primary care providers to whom the member is attributed to if the Health Plan uses an attribution method;
 - c. Any providers who meet the "PCPE Provider" definition; and
 - d. Any providers who meet the "APC Provider" definition.
13. If the member is assigned to, attributed to, or otherwise receives services from more than one primary care providers identified for inclusion within the given reporting period, the Health Plan shall include the member in multiple rows to reflect all of the member's assignment(s) to primary care providers.
14. If the member has discontinuous segments in a given reporting period when the member was assigned to a given provider, the Health Plan shall include multiple rows to reflect each of the assignment segments.
15. If a member is assigned to one provider but attributed to another provider, then multiple rows indicating the member's assignment(s) and attribution(s) during the reporting period shall be included. In this case, the fields with no information (e.g. assignment dates for a member who is attributed but not assigned to a given provider) shall be left blank.
16. The Health Plan shall indicate the Provider Type Code, and Provider Specialty Code as applicable, using information available to the Health Plan via the Provider Master Registry (PMR) file on the Provider.
17. For "Network", the Health Plan shall indicate whether the primary care provider assigned to the member is an out-of- network provider. The Member's assignment or attribution begin date should be used as the anchor date for the provider's Network or Out of Network classification. If the member is both assigned and attributed to the same provider, the

later of the two begin dates should be used as the anchor date.

18. For "Physician Organization", the Health Plan shall indicate any larger entity with whom the provider is affiliated for payment purposes. The Health Plan shall use the "Physician Organization Ref" to populate the variable. If the Physician Organization is marked as Other (i.e. "I") then the Health Plan shall also enter the Physician Organization's name in "Physician Organization Other". If not, the Health Plan shall leave the "Other Physician Organization" field null.
19. In addition Section 3 includes a qualitative question regarding the Health Plan's definition of and methodology for PCP assignment and attribution.

601.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance on the Primary Care Report.

1. Percent Spend on Primary Care Visits: The percentage of the Health Plan's total medical spend that was spent on primary care visits.
2. Percent Spend on Beneficial Primary Care Services: The percentage of the Health Plan's total medical spend that was spent on beneficial primary care services.
3. Percent Total Spend on Primary Care (i.e. Primary Care Visits + Beneficiary Primary Care Services): The percentage of the Health Plan's total medical spend that was spent on primary care.
4. Percent Spend on Low Value Care Services: The percentage of the Health Plan's total medical spend that was spent on select low value primary care services.
5. Percent Spend on Primary Care Supports: The percentage of the Health Plan's total medical spend that was spent on primary care supports.

REPORT 602: DRUG UTILIZATION REVIEW

602.1 Introduction

- A) The purpose of this report is to evaluate the effectiveness and robustness of the Health Plan's Drug Utilization Review (DUR) program consistent with Contract and CMS standards per 42 CFR §438.3(s)(4). The Health Plan's DUR program will also be evaluated against Hawaii Revised Statute 346-59.9, Public Law 115-271, the CMS-2482-F final rule, and other applicable federal and state laws.

602.2 Applicable Contract Sections

- A) Section 4.5.B.16 describes Health Plan responsibilities for all covered outpatient drugs.
- B) Section 6.2.E.7 describes the Drug Utilization Report

602.3 Terms and Definitions

- A) **Criteria:** Criteria are predetermined parameters of drug prescribing and use established in a DUR program for comparison to actual practice. Criteria should be developed or selected by qualified health professionals, and supported by official drug compendia, unbiased drug information, and peer reviewed literature.
- B) **Threshold:** Threshold is a percentage, established by the DUR committee, that identifies the point at which a drug therapy problem exists. For example, a threshold of 95% means the DUR committee has determined that a problem exists if less than 95% of the data collected for a given criteria shows compliance.
- C) **Prospective DUR (ProDUR):** ProDUR involves comparing drug orders with criteria before the patient receives the drug. This type of evaluation is ideal for its preventive potential, and for its individual patient-centered interventions.
- D) **Concurrent DUR (ConDUR):** ConDUR involves reviewing drug orders during the course of therapy. This type of evaluation is ideal where adjustments to drug therapy may be necessary based on ongoing diagnostic and laboratory tests.

- E) **Retrospective DUR:** RetroDUR involves reviewing drug prescribing and use after they have occurred. Although the easiest and least costly approach, with retrospective DUR there is no opportunity to modify therapy for the patients on whom the data were collected.
- F) **Interventions:** the activities selected by the DUR committee to correct drug therapy problems identified during DUR monitoring and evaluation.
- G) The terminology below covers the types of issues that ProDUR ConDUR, and RetroDUR activities hope to identify and address:

Terminology	Definition
Clinical abuse/misuse	Prescription drug abuse is the use of a medication without a prescription, in a way other than as prescribed. Prescription drug misuse may involve not following medical instructions, but the person taking the drug is not looking to "get high."
Drug dosage modification	Change, or alteration, or adjustment of a dose specified in a therapeutic treatment plan or/and administered to a patient.
Drug-drug interactions	Combined dosage of two or more drugs that places a patient at risk for Adverse medical effect.
Inappropriate duration of drug treatment	The dosage prescribed is not compliant with accepted standards or fails to achieve a therapeutic effect (i.e., duration exceeds or falls short of standards).
Drug-patient precautions (age, gender, pregnancy, etc.)	A measure taken, or a warning given in advance to prevent adverse events from happening when a drug is administered.
Therapeutic Interchange	Authorized exchange of therapeutic alternates per previously established and approved written guidelines or protocols within a formulary system.
Appropriate generic use	A treatment guideline that includes definitive orders for a drug's specified dosages which authorized by a prescriber and approved by the state board of pharmacy.
Incorrect drug dosage	Dosage for a specified target therapeutic drug outside the usual adult or pediatric range for the drug's common indications.
Use of formulary medications whenever appropriate	Use of the Health Plan's preferred list of prescription drugs, both generic and brand name, whenever appropriate.
Therapeutic appropriateness and/or duplication	Review for instances where concurrent daily dose of two or more drugs will not yield added therapeutic benefit to warrant the drug cost.
Incorrect drug dosage or duration	An inappropriate dosage prescribed that does not comply with accepted standards to achieve a therapeutic effect (i.e., number of days exceeds or falls short of standards).
Drug disease contraindications	When the potential exists for the occurrence of an adverse reaction on the patient's condition or disease.
Drug allergy interactions	Therapeutic drugs with significant potential for an allergic reaction.
Drug Utilization Review	Drug utilization review (DUR) refers to the evaluation of prescribed, dispensed, administered and ingested medications for safety and efficacy.

602.4 Methodology

A) **This report is organized into three sections.**

B) **Section I** collects information from the Health Plan on the activities of its Pharmacy & Therapeutics (P&T) Committee, where the Health Plans shall report on the P&T Committee's activities during the quarter. Within the embedded Excel document, the Health Plan shall report on the various drugs reviewed, reason for the review, any new or modified criteria established for DUR, and the types of actions to taken by the Health Plan in follow-up. Please report on only the top 5 most utilized drugs. The Health Plan shall also describe preventive education activities conducted during the reporting period, and attach appropriate documentation.

C) In **Section II**, the Health Plan shall gather and report aggregate data on the DUR activities it conducted during the reporting period based on its own DUR criteria, in order to assess the effectiveness and robustness of the Health Plan's ProDUR and RetroDUR program, and the interventions that resulted from findings of the DUR activities.

1. In the first tab ("DUR Activities"), the Health Plan shall gather and report data on the prescriptions reviewed via DUR activities for typical issues identified as part of its DUR activities including drug-disease contraindications; drug-drug interactions; drug- patient precautions(age, gender, pregnancy, etc.); inappropriate duration of drug treatment; incorrect drug dosage; therapeutic duplication; drug abuse/misuse; early refill; and underuse This data shall be reported separately for certain drug classes.
2. In the second tab ("Special Populations") the Health Plan shall report on the specific metrics requested; this tab identifies special populations who require targeted DUR activities, and evaluates the extent to which these populations are monitored by the Health Plan. Instructions pertaining to specific categories or types of data requested are provided below:
 - a. Comprehensive Medication Review (CMR), Targeted Medication Review (TMR), and Other Interventions: The definitions of CMR and TMR shall align with that provided by the Centers for Medicare & Medicaid Services (CMS).

3. The Health Plan shall check to see if a member has had a CMR at least once since the first day of the fourth quarter prior to the current reporting quarter. In other words, for the reporting quarter between July 1 – September 30, the Health Plan shall check to see if a CMR was completed since July 1st of the prior calendar year.
 - a. While Medicare members may be the primary Medicaid members receiving CMRs and TMR, the Health Plan is encouraged to check on medication therapy management (MTM) programs occurring to support Medicaid members, including at FQHCs and other settings where MTM is provided to the member as part of a value-based payment arrangement.
4. The Health Plan is asked to use the “Which members does the Health Plan target within this population for these reviews?” field to identify the sub-population(s) it targeted in providing each type of intervention, if the targeted population is a subset of all members in the category. For example, among all members overlapping prescriptions for ten or more medications, if the Health Plan only targeted members with overlapping prescriptions for fifteen or more medications, or only targeted people with overlapping Medicare plans, the Health Plan shall provide this context.
5. If the Health Plan has implemented any other interventions to target specific members in various sub-populations, it should describe briefly the intervention implemented after the word “DESCRIBE” in the “Data Requested” field, and specify who the intervention targeted in the “Which members does the Health Plan target within this population for these reviews?” field.
 - a. Space for up to three customized interventions is provided to capture the diversity of work that may be in progress. If the Health Plan has more than three customized interventions, the Health Plan is asked to include information on the additional intervention in response to the qualitative question provided in Section III. If the Health Plan has fewer than three customized interventions, the Health Plan is asked to enter “N/A” in all corresponding fields to clarify that the row is not applicable and no data is available.
6. In the row where the Health Plan is asked to provide information on the “Number of unique members [in the category] who received one or more

Health Plan interventions identified above,” the Health Plan shall provide a de-duplicated count of members in the category who received any type of MTM/MTM-Like interventions identified in the previous rows.

7. Excessive Polypharmacy:

- a. To identify overlapping prescriptions, the Health Plan shall evaluate available days supply during the reporting period of any medication filled during or prior to the reporting period. If a given member had ten or more prescriptions with at least one day of supply at any time during the reporting period, the member is identified as having “overlapping prescriptions for ten or more medications” during the reporting period.
- b. For the purposes of this report, a unique prescription is identified by its Generic Product Identifier® (GPI) “drug base name.”
- c. Prescriptions with different drug base names shall be treated as different. Prescriptions with the same drug base name shall be grouped as the same prescription, and not counted separately.

8. Multiple Chronic Conditions:

- a. To identify members with three or more co-morbid chronic conditions (i.e. multiple chronic conditions), the Health Plan shall refer to the tab named “Comorbid Conditions” in the “DUR Reference Tables” document.
- b. If a member has had one or more diagnostic codes for a particular condition at least two times during the 24-month period prior to the first day of the reporting period, the member is identified as having that condition. As an example, the member has “Alzheimer’s Disease and Related Disorders or Senile Dementia” if they have had
- c. any two of the diagnostic codes associated with this condition appear in their health records or if the same diagnostic code has appeared more than once, during the specified period.
- d. If a member has three or more conditions (e.g. Alcohol Use Disorder and Atrial Fibrillation and Asthma) then they are considered to have three or more comorbid conditions. Health Plans

should not simply include a member if they have three or more diagnostic codes within the list.

- e. In identifying these members, the Health Plan shall include all members, including those with aligned and misaligned Medicare plans.

9. Liver Disease and Chronic Kidney Disease:

- a. In addition to identifying members with liver and kidney disorders as conditions contributing to the three or more co-morbid conditions, the Health Plan shall also tease out members with liver and kidney disorders separately.
- b. The diagnostic codes to identify liver disease and kidney disease are listed in separate tabs ("Liver Disease" and "Chronic Kidney Disease") in the "DUR Reference Tables" document, but reference the same definitions provided when these conditions are included in the "Comorbid Conditions" tab.

10. Medication Adherence:

- a. The Health Plan shall use it's available list of maintenance medications to identify members who required maintenance medications during the reporting period.
 - 1) Maintenance medications must be identified based on the GPI "drug base name" level.
 - 2) Maintenance medications shall not include medications used to treat pain or substance use disorders (e.g. opioids, methadone).
 - 3) The Health Plan shall attach its list of maintenance medications to the report.
- b. The Health Plan shall identify non-adherence to any maintenance medications (this analysis shall not be limited to a specific subset of the population receiving maintenance medications).
 - 1) Non-adherence for the purposes of this report is defined as a drop below 80% in the proportion of days covered (PDC) by

the drug during the reporting period.

11. Targeted Programs for Special Populations (1-6):

- a. The Health Plan may have additional MTM or MTM-like programs targeting other special populations (e.g. members with uncontrolled diabetes, chronic pain, etc.). Space is provided here for the Health Plan to describe its work with these populations.
- b. The Health Plan shall identify the special population after the word "DESCRIBE" in the "Category" field, and quantify the interventions provided.
 - 1) Space for up to six special populations is provided to capture the diversity of work that may be in progress. If the Health Plan has more than six special populations with targeted programs, the Health Plan is asked to include information on the additional intervention in response to the qualitative question provided in Section III. If the Health Plan has fewer than six targeted programs for special populations, the Health Plan is asked to enter "N/A" in all corresponding fields to clarify that the row is not applicable and no data is available.

12. MTM/All Populations:

- a. Given the many potential opportunities and venues by which members may receive MTM/MTM-like services, this category is provided for Health Plans to include a deduplicated count of members receiving MTM/MTM-like interventions across any and all programs.
- b. Here, space for up to five different types of customized interventions are provided in the event that different types of interventions are used to target different special populations.
- c. Here, if the Health Plan has more than five customized interventions in place, the Health Plan is asked to label the fifth intervention as "Multiple Interventions," populations with targeted programs, the Health Plan is asked to consolidate all the remaining

interventions here the additional intervention, and provide additional context on the multiple interventions consolidated in response to the qualitative question provided in Section III. If the Health Plan has fewer than five customized interventions across its MTM/MTM-like services, the Health Plan is asked to enter "N/A" in all corresponding fields to clarify that the row is not applicable and no data is available.

13. Opioid Monitoring:

- a. The Health Plan shall identify members with a combined total average daily morphine milligram equivalents (MME) of greater than 120 mg per day at any time during the reporting period using Health Plan available definitions.
- b. Members shall be excluded if they are receiving palliative care or hospice services.
- c. Members shall be excluded if they are undergoing active cancer treatment (i.e. member has had at least 2 encounters within the prior year with any diagnosis of cancer).
- d. Opioid Naïve is defined as no indication of opioid use in the past 90 days from a prescription, self report, or a dispensing event.

14. Medication-Related Poisoning:

- a. To identify members with medication-related poisoning, the Health Plan shall refer to the tab named "Medication- Related Poisoning" in the "DUR Reference Tables" document.
- b. If a member has had at least one diagnostic code for medication-related poisoning during the 24-month period prior to the first day of the reporting period, the member is identified as having that condition.

15. **Section II** also includes qualitative questions to gather information on follow-up actions taken by the Health Plan in response to findings from its DUR Activities; and the Health Plan's lock-in program.

D) In **Section III**, the Health Plan shall answer a set of qualitative questions.

1. Does the Health Plan have its own DUR Board?
2. Does the Health Plan integrate PDMP data into its POS Edits?
3. Does the Health Plan have an edit in its POS system that alerts the pharmacy provider that the ME daily dose prescribed has been exceeded?
4. Does the Health Plan have documented programs in place to either manage or monitor the appropriate use of antipsychotic and stimulant drugs in children?
5. Does the Health Plan have a comprehensive DUR program with the appropriate selection, criteria, thresholds, and interventions for drugs included in the DUR program

602.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance on the report.

1. The Health Plan has its own DUR Board
2. The Health Plan has PDMP data integrated into its POS Edits
3. The Health Plan has an edit in its POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded
4. The Health Plan has documented programs in place to either manage or monitor the appropriate use of antipsychotic and stimulant drugs in children
5. The Health Plan has a comprehensive DUR Program with the appropriate selection, criteria, thresholds, and interventions for drugs included in the DUR Program
6. Percent of members with overlapping prescriptions for seven or more medications who received a drug-drug interaction review
7. Percent of members with three or more co-morbid conditions who received a drug-disease interaction review
8. Percent of members with renal and/or hepatic insufficiency who received a

drug-patient interaction review

9. Percent of members with one or more chronic conditions requiring maintenance medications who received a retrospective review to check for unfilled prescription
10. Percent of members taking any opioid medications who received more than 120 MMEs at any time
11. Percent of members with overlapping opioid/ benzodiazepine, or opioid/sedative prescriptions who received concurrent drug reviews
12. Percent of prescriptions filled among those with drug-disease contraindications
13. Percent of prescriptions filled among those with potential drug-drug interactions
14. Percent of prescriptions filled among those with drug-patient precaution alerts
15. Percent of prescriptions filled among those with excessive duration alerts
16. Percent of prescriptions filled among those with therapeutic duplication alerts
17. Percent of opioid prescriptions filled among those with overuse alerts
18. Percent of benzodiazepines prescriptions filled among those with overuse alerts
19. Percent of opioid prescriptions filled among those with apparent drug abuse/misuse alerts
20. Percent of stimulant prescriptions filled among those with apparent drug abuse/misuse alerts

REPORT 603: PRIOR AUTHORIZATIONS MEDICAL

603.1 Introduction

- A) The purpose of the Prior Authorizations (PA) Medical Report is to monitor and evaluate the Health Plan's use of PAs for medical services. Additionally, this report will monitor the Health Plan's work on innovative and streamlined processes for PA requirements.

603.2 Applicable Contract and Health Plan Manual Sections

- A) Section 5.2.B (Utilization Management) describes the requirements for a Health Plan's prior authorization program.
- B) Section 6.2 (Prior Authorizations Reports – Medical and Pharmacy) describes the contract requirements report to ensure compliance with 42 CFR §438.210(c) and 42 CFR §438.404 and as allowed by 42 CFR §438.66(c).

603.3 Terms and Definitions

- A) **Prior Authorization (PA):** A decision by the Health Plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary for the patient.

603.4 Methodology

- A) **This report is organized into two sections:**
 - 1. Only data on prior authorizations with decisions on any dates within the reporting period shall be included in the report, even if prior authorizations were initiated prior to the first day of the reporting period. Please see below for instructions on how to include appeals data for PAs that have already been reported to DHS and at the time of report submission the Health Plan was unaware of an impending appeals request.
- B) **Section I: Member-level Data File.** The Health Plan shall provide information on prior authorization approvals and denials in the report template embedded by referring to "PAM_MLDF_DataFormat.xlsx" in this report's subfolder within the "Report Reference Tables and Data Submission Format" folder.

1. The Health Plan shall provide information on the CPT/HCPCS procedural codes that require PAs and report on PA metrics such as number of requests, denials, approvals, and appeals.
 - a. The Health Plan shall use the embedded worksheet titled "Procedural Code Worksheet" to determine which category the PA request falls under and notate within the MLDF for each PA. The service categories include:
 - 1) At Risk Services
 - 2) Autism Services
 - 3) Diagnostic Testing
 - 4) Durable Medical Equipment/Medical Supplies
 - 5) Home and Community Based Services
 - 6) Home Health Services
 - 7) Inpatient Hospital Services
 - 8) Outpatient Hospital Services
 - 9) Physician Services
 - 10) Preventative Services
 - 11) Rehabilitation Services
 - 12) Transportation Services
 - 13) Behavioral Health Services
 - 14) Other Services
 - b. The Health Plan shall report the total number of procedural codes that require PAs across all categories in the report template.
 - c. The Health Plan shall report the type of PA request under the PA_Request_Type category as standard, expedited or retrospective. The Health Plan shall report the location in which the PA will take

place. The service locations are listed below on the reference table.

- d. The Health Plan shall report the context in which the PA is being requested.
 - 1) Transition Service
 - 2) Continuation of Service
 - 3) New Service
- e. The decision of each PA will be captured in the PA_Decision service category as approved or denied. Plans are required to report all prior authorizations.
- f. The Health Plan shall report the date in which the standard or expedited PA decision was made.
- g. The Health Plan shall report the time at which the expedited PA decision was made. The data reference table details that the hours are only required for expedited appeals. Standard appeals are measured in days.
- h. If a PA request does not have a decision in less than 24 hours, the Health Plan shall document the decision time as one day, plus the subsequent number of hours and/or days until a decision is made.
- i. For all denied PAs, the Health Plan shall report the reason for denial in the HC_Dec_Code category. The categories are located on the data reference table.
- j. Health Plan shall also provide data on the status of any prior authorization decisions that have been appealed including:
 - 1) In Progress
 - 2) Overturned
 - 3) Upheld
 - 4) Withdrawn

- C) **In Section II: Prior Authorization Procedures**, the Health Plan shall provide qualitative information on its prior authorization procedures and processes as well as its efforts and progress in implementing innovative and streamlined utilization management programs.

603.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. Percent of standard prior authorization requests with no extension requiring greater than 7 calendar days for a decision.
2. Percent of expedited prior authorization requests with no extension requiring greater than 72 hours for a decision.
3. Median time from request to decision for standard prior authorization requests with no extension.
4. Median time from request to decision for expedited prior authorization requests with no extension.
5. Prior authorization approval rate per 100 prior authorizations requests.
6. Percent of overturned prior authorization denials.
7. Health Plan is actively collaborating with other Med-QUEST Health Plans to implement an innovative and streamlined utilization management/prior authorization protocol for providers.
8. Health Plan has a prior authorization committee to evaluate PA requirements that have resulted in streamlined and improved prior authorization procedures.
9. Health Plan has an electronic prior authorization portal/process for all providers to identify and submit prior authorization requests.
10. Health Plan has a robust prior authorization program that eliminates prior authorization requirements for select providers/practices.
11. Health Plan offers a minimum 60-day grace period on prior authorization protocols for patients who are already stabilized on a particular treatment upon enrollment in the plan.

12. Prior Authorization approval is valid for the duration of all prescribed/ordered courses of treatment.
13. Health Plan revokes, limits, conditions, or restricts coverage for authorized care provided within 45 business days from the date authorization was received for any services.
14. Does the Health Plan post the list of all items and services, excluding drugs, that are subject to prior authorization, as required in 42 CFR 438.210(f)(1)?”
15. Does the Health Plan post online prior authorization data for all items and services excluding drugs, as required in 42 CFR 438.210(f)?”

REPORT 604: PRIOR AUTHORIZATIONS PHARMACY

604.1 Introduction

- A) The purpose of the Prior Authorizations (PA) Pharmacy Report is to monitor and evaluate the Health Plan's use of PAs for pharmacy. Additionally, this report will monitor the Health Plan's work on innovative and streamlined processes for PA requirements for drugs.

604.2 Applicable Contract and Health Plan Manual Sections

- A) Section 5.2.B (Utilization Management) describes the requirements for a Health Plan's prior authorization program.
- B) Section 6.2 (Prior Authorizations Reports – Medical and Pharmacy) describes the contract requirements report to ensure compliance with 42 CFR §438.210(c) and 42 CFR §438.404 and as allowed by 42 CFR §438.66(c).

604.3 Terms and Definitions

- A) **Prior Authorization:** A decision by the Health Plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary for the patient.
- B) **Complete Prior Authorization:** A prior authorization request that includes all information and documentation necessary for the Health Plan to review the request and make a coverage determination.
- C) **Incomplete Prior Authorization:** A prior authorization request that does not contain all information and documentation required for the Health Plan to evaluate the request and render a coverage determination.

604.4 Methodology

- A) **This report is organized into three sections:**

1. Only data on prior authorizations with decisions on any dates within the reporting period shall be included in the report, even if prior authorizations were initiated prior to the first day of the reporting period. Please see below for instructions on how to include appeals data for PAs that have already been reported to DHS and at the time of report submission the Health Plan was unaware of an impending appeals

request.

- B) **Section I: Drugs Requiring Prior Authorization.** The Health Plan shall use the embedded worksheet to notate the drug name and reason for which the Health Plans require prior authorization for each drug category.
- C) **Section II: Member-level Data File.** The Health Plan shall provide information on pharmacy prior authorization approvals and denials in the report template embedded by referring to "MLDF Reference Table" tab. The Health Plan shall provide information on the drugs and corresponding reason for which the Health Plan requires PA for that drug/drug category, and report on PAs metrics such as number of requests, denials, approvals, and appeals.
1. The Health Plan shall use the embedded worksheet titled "Drugs Requiring PA" to list the names of all drugs for which a PA request was received during the quarter. Additional information such as whether it is formulary or non-formulary and reason for inclusion in the Health Plan's PA program will be required. The Health Plan shall report the total number of drugs that required PAs in the reporting period in the designated box .
 2. The Health Plan shall report key PAs data in the embedded worksheet titled "MLDF."
 3. The decision of each PA will be captured in the PA_Decision service category as approved or denied. Plans are required to report all prior authorizations.
 4. The Health Plan shall report the "Number of Rejections where Member was Provided 72-hour Emergency Supply."
 - a. If a prescription cannot be filled when presented to the pharmacist due to a prior authorization requirement and the prescriber's office cannot be reached, then the Health Plan shall instruct the pharmacy to dispense a seventy-two (72) hour emergency supply of the prescription.
 - b. The pharmacy is not required to dispense a seventy-two (72) hour supply if the dispensing pharmacist determines that taking the prescribed medication would jeopardize the Member's health or safety, and he or she has made good faith efforts to contact the

prescriber.

5. For prior authorization requests that are received as complete, Health Plans shall record the applicable denial reason in the HC_DEC_CODE field if the request is denied.
6. If a prior authorization request is incomplete and does not contain sufficient information for the Health Plan to render a determination, the Health Plan shall request the missing information from the provider and record "0U: Additional Patient Information Required" in the MLDF. The Health Plan must also document the supplemental information requested. Once all required information has been received and the prior authorization request is considered complete, the Health Plan shall conduct its review and record the final determination. If the request is denied, the applicable final denial reason shall be reported in the FINAL_DECISION_CODE field.
 - a. 96-Hour Disposition: For prior authorization requests, the Health Plan may take up to 24 hours to request any additional information needed to complete its review. Providers then have up to 48 hours to submit the requested information. Once the Health Plan receives all necessary information, it has up to 24 hours to issue an approval or denial determination. If the requested information is not received within 48 hours, the Health Plan must issue a denial within the following 24 hours. In no case should an incomplete prior authorization request remain unresolved beyond 96 hours. If the requested information is not received within the 96-hour timeframe, the Health Plan shall issue an administrative denial for insufficient information and report FINAL_DECISION_CODE = "0P - Requested Information Not Received." Requests that exceed the 96-hour timeframe due to missing information must not be closed without a determination. Administrative denials reported under denial code 0U are excluded from KPI #3 calculations.
 - b. Clinical Determination with Missing Information: If a prior authorization request is missing some information, but the information available is sufficient enough for the Health Plan to make a clinical determination, the request shall remain subject to the 24-hour decision requirement. In these cases, the Health Plan

should not treat the request as an incomplete prior authorization requiring the 96-hour incomplete PA process. The 96-hour timeframe applies only when the missing information is necessary to make an approval or denial determination. If the Health Plan can render a determination based on the information submitted, the decision must be made within the standard 24-hour timeframe.

D) In **Section III: Prior Authorization Procedures**, the Health Plan shall provide qualitative information on its prior authorization procedures and processes as well as its efforts and progress in implementing innovative and streamlined utilization management programs.

604.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance.

1. Percent of complete prior authorization requests requiring greater than 24 hours for a decision
2. Median time from request to decision for complete prior authorization requests
3. Percent of prior authorization requests with incomplete information requiring greater than 24 hours for a response.
4. Median time from request to response for incomplete prior authorization requests.
5. Prior Authorization Approval Rate per 100 Prior Authorization Requests
6. Percent of Overturned prior authorization denials
7. Health Plan provides accurate, patient-specific, and up-to-date formularies that include PA requirements in EHR systems for purposes that include e-prescribing.
8. The Health Plan either does not have step therapy requirements, or has step therapy requirements that may be overridden.
9. The Health Plan requires patients to repeat step therapy protocols or retry therapies failed previously (even if under other benefit plans) before qualifying for coverage of a current effective therapy

REPORT 605: MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY

605.1 Introduction

- A) The purpose of this report is to monitor and ensure the Health Plan's compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

605.2 Applicable Contract and Health Plan Manual Sections

- A) Section 4.4.A.8 (Covered Benefit Requirements for Parity in Mental Health and Substance Use Disorders) contains coverage and parity requirements per 42 CFR Part 438, Subpart K.
- B) Section 6.2.E.5 (Report Descriptions) contains information on the required Mental Health and Substance Use Disorder Parity documentation per 42 CFR §438.3(n) and contractual report requirements.

605.3 Terms and Definitions

- A) **Quantitative Treatment Limits (QTLs):** numerical limitations, such as on number of annual, episodic, and lifetime visit limits and day limits, to benefits for services.
- B) **Non-quantitative Treatment Limits (NQTLs):** processes, strategies, evidentiary standards, and other criteria that limit the scope or duration of benefits for services.
- C) **Mental Health Parity and Addiction Equity Act (MHPAEA) Benefit Classifications:** Under the MHPAEA regulations, the six classifications of benefits are:
 - 1. Inpatient, in-network
 - 2. Inpatient, out-of-network
 - 3. Outpatient, in-network
 - 4. Outpatient, out-of-network
 - 5. Emergency care

6. Prescription drugs

- D) **Other outpatient services:** non-office visit services and supplies including but not limited to laboratory tests, x-rays and diagnostic imaging, nonemergency medical transportation, home health, hospice, outpatient surgery facility fee, outpatient surgery physician/surgeon fee, etc.
- E) **Substantially All Test:** Also known as the two-thirds test, any financial requirement for mental health/substance use disorder benefits must apply to two-thirds of medical/surgical benefits in the relevant classification.
- F) **Predominant Test:** If a type of financial requirement applies to substantially all medical/surgical benefits in a classification, the “**predominant level**” is the level that applies to more than one- half of the medical/surgical benefits in that classification subject to the financial requirement.

605.4 Methodology

- A) **This report is organized into three sections.**
 - 1. Section 1 covers non- financial QTLs.
 - 2. Section II covers NQTLs.
 - 3. Section III covers financial requirements.
- B) In **Section 1: Quantitative Treatment Limits**, the Health Plan shall report if they impose any more restrictive non-financial QTLs such as annual visits, annual days, episode visits, episode days, lifetime visits, or lifetimes days on MH/SUD benefits compared to substantially all medical/surgical benefits in each benefit classification. If the Health Plan does not impose any more restrictive QTLs, then they shall select “None” for each classification.
 - 1. The Health Plan shall describe in more detail any more restrictive QTLs in the embedded worksheet.
 - 2. The worksheet is broken up into distinct sections corresponding to each of the benefit classifications with medical/surgical benefits in columns A and B and MH/SUD benefits in columns D and E.
 - 3. The Health Plan shall only fill out sections for which they reported having more restrictive QTLs.

4. Common benefits under each classification are provided in column A (medical/surgical) and column D (MH/SUD). The Health Plan could add additional benefits if needed in the blank spaces. The Health Plan shall then write the type of QTLs that apply to each of the benefits in B (medical/surgical) and . If none then the Health Plan shall report "None".

C) In **Section II: Non-Quantitative Treatment Limitations**, the Health Plan shall report if they do or do not impose any of the following NQTLs in any of the six benefit classifications in a manner that is more restrictive than for medical/surgical benefits.

1. Medical Management standards limiting or excluding benefits based on medical necessity, or medical appropriateness, or based on whether the treatment is experimental or investigative.
2. Prior authorization and ongoing authorization requirements
3. Concurrent review standards
4. Formulary design for prescription drugs
5. For plans with multiple network tiers (such as preferred providers and participating providers), network tier designs
6. Standards for provider admission to participate in a network, including reimbursement rates
7. Methods for determining usual, customary, and reasonable charges
8. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (i.e., "fail-first" policies or "step therapy" protocols).
9. Restrictions on applicable provider billing codes
10. Standards for providing access to out-of-network providers
11. Exclusions based on failure to complete a course of treatment
12. Restrictions based on geographic location, facility type, and provider specialty

13. If the Health Plan selected "Yes" for any of the NQTLs, then the Health Plan shall describe in more detail the NQTL(s) and which benefit classification(s) they are imposed on including processes, strategies, evidentiary standards, and other factors.

D) In **Section III: Financial Requirements**, the Health Plan shall report if they impose any more restrictive financial requirements, such as deductibles, co-payments, co-insurance, annual out-of-pocket maximums, or life-time out-of-pocket maximums, on MH/SUD benefits than the predominant financial requirement that applies to substantially all medical/surgical benefits in each benefit classification.

1. If the Health Plan reports no more restrictive financial requirements, then they shall select "None" for each benefit classification.
2. If the Health Plan selected any more restrictive financial requirements, then they shall complete the embedded worksheet "Financial Calculations".
3. The Health Plan shall only complete sections for which they reported having more restrictive financial requirements.
4. Table 1 shall be completed only if they Health Plan reported having more restrictive deductibles for any classification.
5. For (A), the Health Plan shall report the more restrictive deductible(s) amounts, if different amounts apply to different coverage units (e.g., individual and family), and for benefits separate from the overall deductible.
6. The Health Plan shall attest if the deductible(s) meet the substantially all test for medical/surgical benefits of the same classification(s).
7. Table 2 shall be completed only if the Health Plan reported having more restrictive annual or lifetime out-of-pocket maximums for any classifications.
8. For (A), the Health Plan shall report the more restrictive out-of-pocket maximum(s), and if there are different out-of-pocket maximums for different coverage units.

9. The Health Plan shall complete table 3 if they reported having more restrictive copayments or coinsurance for any classifications. The table is broken up by benefit classification and only classifications for which more restrictive copayments or coinsurance were reported need to be completed.
10. Column A provides a list of fees for each benefit classification area.
11. The Health Plan shall report the more restrictive copayment or coinsurance amount in column C.
12. The Health Plan shall report the projected FY expenses in column D.
13. The Health Plan shall report the projected expense for this benefit as percent of projected expense for all benefits subject to copayment in F (if a restrictive copayment is being reported).
14. The Health Plan shall report the projected expense for this benefit as percent of projected claims subject to coinsurance (if a restrictive coinsurance is being reported).
15. The Health Plan shall report out the result of the substantially all cost share type in column H.
16. The Health Plan shall report out the result of the predominant test in column I.

605.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance on MH/SUD parity:

1. Number of more restrictive non-financial quantitative treatment limits on MH/SUD benefits compared to medical/surgical benefits in one or more classifications.
2. Number of more restrictive financial quantitative treatment limits on MH/SUD benefits compared to medical/surgical benefits in one or more classifications.
3. Number of more restrictive financial non-quantitative treatment limits on MH/SUD benefits compared to medical/surgical benefits in one or more

classifications.

REPORT 606: OVER-UTILIZATION AND UNDER- UTILIZATION OF SERVICES

606.1 Introduction

- A) The purpose of this report is to evaluate the Health Plan's required mechanisms to detect and appropriately address both underutilization and overutilization of services, and the results of this process.

606.2 Applicable Contract Sections

- A) Section 6.5.E.8 (Utilization Management reports) describes the intent of this report.

606.3 Terms and Definitions

- A) **Unplanned Re-Admissions within 30 days:** unplanned re-admissions are identified as a re-admission that is not categorized as a planned readmission, occurring during the reporting period. The measure uses the CMS 30-day Hospital-Wide Readmission (HWR) Measure Planned Readmission Algorithm, Version 4.0. CMS definitions are based on the Agency for Healthcare Research and Quality's (AHRQ) Clinical Classification Software (CCS) outputs; for more details on AHRQ's CCS system, see: https://www.hcupus.ahrq.gov/tools_software.jsp

606.4 Methodology

- A) **This report is organized into two sections.**
1. Section 1 gathers several utilization metrics that are potential indicators of over- or under-utilization of health services from a variety of lenses.
 2. Section 2 gathers qualitative data from the Health Plan on its current processes for detecting and addressing under- and over- utilization of services.
- B) The Health Plan shall begin by identifying all members enrolled with the Health Plan on the first day of the reporting period who were at least 2 years old on the first day of the reporting period, with a gap in enrollment of no more than 30 days during the 12 months prior to the reporting period. These members shall serve as the denominator for this report.

1. For these members, the Health Plan shall calculate the total number of member months during the reporting period.
2. On these members, the Health Plan shall gather administrative data for 12-month period prior to the last day of the reporting period (i.e. a full year worth of data that includes the reporting period), to identify:
 - a. Member's age as of the first day of the reporting period;
 - b. Members who need or utilize behavioral health services (see reference table); and
 - c. Other diagnostic and utilization information to calculate the metrics below.
3. Among the included members, the Health Plan shall specifically identify inpatient admissions for the following conditions during the reporting period, using existing definitions of these conditions available to the Health Plan:
 - a. COPD
 - b. Heart Attack
 - c. Heart Failure
 - d. Pneumonia
 - e. CABG
 - f. Hip/knee replacements
 - g. Stroke
 - h. Blood stream infections
 - i. Urinary Tract Infections
4. Among the included members, the Health Plan shall also identify the total number of ED visits with the following primary diagnoses during the reporting period, using existing definitions of these conditions available to the Health Plan:

- a. mental health, alcohol, or substance misuse
 - b. dental conditions
 - c. asthma
5. Among the included members, the Health Plan shall identify members who have had one or more of the following types of utilization during the reporting period.
- a. Members with one or more visits to their assigned PCPs
 - b. Members utilizing outpatient BH services (see Reference Table)
 - c. Total number of ED visits for any reason, as well as:
 - 1) Members with one or more ED visits for any reason
 - 2) Members with two or more ED visits for any reason
 - d. Number of inpatient admissions
 - e. Inpatient admissions processed through ED
 - f. Number of members hospitalized
 - g. Number of inpatient admissions that resulted in an in-hospital death
 - h. Number of discharges from the inpatient setting, separated by:
 - 1) Discharges to home or self-care
 - 2) Discharges to SNF for post-acute care
 - 3) Discharges to home health agency for post-acute care
 - 4) All other types of discharges
 - i. Number of unplanned readmissions within 30 days of discharge (see reference table)
 - j. Total inpatient days
6. Among the included members, the Health Plan shall identify members who

have had one or more of the following types of utilization during the reporting period and prior three rolling quarters (total of one year). For example, if the reporting period ends on September 30, then the Health Plan shall identify members with the following types of utilization between October 1 of the prior year and September 30 of the current year.

- a. Members with four or more ED visits for any reason
- b. Members with one or more visits to their assigned PCP
- c. Members whose PCP has changed once
- d. Members whose PCP has changed more than once

7. Using data gathered previously, the Health Plan shall additionally identify:

- a. Members with an ED visit in the reporting period, without a visit to the member's PCP in the reporting period or prior 3 rolling quarters
- b. Members with two or more ED visits in the reporting period, without a visit to the member's PCP in the reporting period or prior 3 rolling quarters
- c. Specific data to be gathered above require the use of DHS-provided reference tables, including (1) Identifying members needing and utilizing behavioral health services, and (2)
- d. Identifying unplanned admissions. To identify these members/incidents the Health Plan shall reference "Reference Tables.xlsx" in this report's subfolder in the "Report Reference Tables and Data Submission Formats" folder.
- e. Members Needing/Utilizing BH Services:
 - 1) The Health Plan shall use the definitions provided in the four "Need-Use BH Services" tab.
 - 2) "Need-Use BH Services (1_Dx)" includes behavioral health diagnostic codes
 - 3) "Need-Use BH Services (2_ProcCd)" includes procedure codes (CPT and HCPCS) associated with behavioral health

services

- 4) "Need-Use BH Services (3_NDC)" includes drugs prescribed to treat behavioral health conditions.
- 5) "Need-Use BH Services (4_Rev Cd)" includes behavioral health revenue codes
- 6) To comprehensively identify members needing/utilizing behavioral health services, the Health Plan shall identify members with indication of either a BH diagnosis, procedure, prescription, or revenue code during the 12 months prior to the last day of the reporting period. A member appearing on any of the four lists shall be included in this population.

f. Members Utilizing Outpatient BH Services:

- 1) The Health Plan shall use the definitions provided in the "Need-Use BH Services (2_ProcCd)" includes procedure codes (CPT and HCPCS) associated with outpatient behavioral health services
- 2) To comprehensively identify members utilizing behavioral health services, the Health Plan shall identify members with any utilization corresponding to the codes provided in the tab above during the reporting period.

g. Unplanned Re-Admissions within 30 days

- 1) Unplanned re-admissions are identified as a re-admission that is not categorized as a planned readmission, occurring during the reporting period. The measure uses the CMS
- 2) 30-day Hospital-Wide Readmission (HWR) Measure Planned Readmission Algorithm, Version 4.0. CMS definitions are based on the Agency for Healthcare Research and Quality's (AHRQ) Clinical Classification Software (CCS) outputs; for more details on AHRQ's CCS system, see: https://www.hcupus.ahrq.gov/tools_software.jsp

3) The planned readmission algorithm follows two principles to identify planned readmissions:

- h. Select procedures and diagnoses, such as transplant surgery, maintenance chemotherapy/ radiotherapy/ immunotherapy, rehabilitation, and forceps delivery, are considered always planned (Table B1 and Table B2).
 - i. Some procedures, such as colorectal resection or aortic resection, are considered either planned or unplanned depending on the accompanying principal discharge diagnosis (Table B3). Specifically, a procedure is considered planned if it does not coincide with a principal discharge diagnosis of an acute illness or complication (Table B4).
 - j. Tables B1, B2, B3 and B4 are provided in the reference tables document embedded above to support the health plan in identifying planned admissions.
 - k. $\text{Unplanned Re-admissions} = \text{All Re-Admissions} - \text{Planned Re-Admissions}$
- C) In **Section 1**, using the data gathered above, the Health Plan shall complete the two tabs, labeled "Inpatient Measures" and "Emergency-Outpatient Measures" in aggregate level data file. Several metrics in the second table in each tab will be auto- populated.
- D) In **Section 2**, The Health Plan shall qualitatively describe its process for evaluating its utilization patterns for instances of over, under and inappropriate utilization.

606.5 Key Performance Indicators (KPIs)

- A) DHS shall use the following KPIs to evaluate Health Plan performance.
- 1. Percent of members 40-64 years who have not visited their PCP in the past year
 - 2. Percent of members whose PCP has changed more than once in the past 4 rolling quarters

3. Percent of members utilizing BH services of those needing BH services
4. Percent of members with an ED visit who have not visited their PCP in the past year
5. Percent of ED Visits that resulted in hospitalization
6. Number of ED visits per 1000 members for mental health, alcohol or substance misuse
7. Number of ED Visits per 1000 members for asthma, ages 18-39 years
8. Percent of members with two or more ED visits
9. Percent of members with four or more ED Visits in the past year
10. Mortality Rate per 100 hospitalized members
11. Rate of unplanned readmissions within 30 days per 100 discharges
12. Post-Acute SNF to Home Health discharge ratio
13. The Health Plan has identified areas of over, under and
14. inappropriate utilization and has a thoughtful strategy to address these areas.

REPORT 607: PROVIDER PREVENTABLE CONDITIONS

607.1 Introduction

- A) The Health Plan shall report all identified provider preventable conditions (PPCs) in their encounter data submissions.
- B) Per Section 2702 of the Patient Protection and Affordable Care Act of 2010, states are required to implement non-payment policies for provider preventable conditions including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs).

607.2 Applicable Contract Sections

- A) Section 6.2 Report Descriptions describes the Provider Preventable Conditions report as a demonstration of compliance with 42 CFR §447.26.
- B) Section 7.2 Health Plan General Responsibilities asserts the Health Plan shall not pay for healthcare-acquired conditions or other Provider Preventable Conditions identified by CMS or DHS.

607.3 Terms and Definitions

- A) **Provider Preventable Conditions (PPCs):** a condition that was not present on admission that meets the definition of a “health care-acquired condition” or an “other provider-preventable condition” as defined in this section.
- B) **Health Care-Acquired Conditions (HCACs):** conditions acquired through any inpatient hospital setting. For a complete list of HCACs and the associated ICD-10 Codes, please refer to <https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-acquired-conditions-hac/icd-10>.
- C) **Other Provider-Preventable Conditions (OPPCs):** conditions acquired through any healthcare setting, including:
 - 1. Wrong Surgical or other invasive procedure performed on patient (ICD-10-CM Y65.51)
 - 2. Surgical or other invasive procedure performed on the wrong patient (ICD-10-CM 65.52)
 - 3. Surgical or other invasive procedure performed on the wrong body part

(ICD-10-CM 65.53)

607.4 Methodology

This report is organized into two sections.

- A) In **Section 1: Provider Preventable Conditions Events**, the Health Plan shall provide a list of all PPC events that occurred during the reporting period. The information required on PPC events can be found in the DataFormat file.
- B) In **Section 2: Provider Preventable Conditions Treatment Claims**, the Health Plan shall provide an extract of all claims the Health Plan adjudicated during the reporting period for the course of treatment associated with each PPC event. The PPC event of these claims does not need to be limited to the reporting period; health plans can report all claims associated with PPC events that have occurred over the last 3 years, as long as the Health Plan adjudicated the claim during the reporting period. The Health Plan shall list all claims adjudicated during the reporting period, regardless of whether they were submitted to HPMMIS. The information required for each claim associated with a PPC event can be found in the DataFormat file.
 - 1. If a claim is associated with multiple PPCs, the Health Plan shall report one line for each PPC.
 - 2. When referencing the current CMS list of HCACs, use hospital admission date as a reference date. For example, the FY2025 list of HCACs is applicable to hospital stays with admission dates between 10/1/24-9/30/25.
- C) In **Section 3: Provider Preventable Condition Monitoring**, the Health Plan shall provide an overview of how the plan monitors incoming claims to identify PPC events and the associated claims to ensure providers are not paid for services associated with PPCs.

607.5 Key Performance Indicators (KPIs)

- A) DHS shall use the following KPIs to evaluate Health Plan performance.
 - 1. Number of PPC associated claims the Health Plan paid during the reporting period

2. The Health Plan has a system in place to monitor claims for PPC events