HEALTH PLAN MANUAL

Part III – Reporting Guidance

Department of Human Services, Med-QUEST Division

April 1st, 2022

TABLE OF CONTENTS

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; and additional DHS review processes, if applicable.

Submission Instructions

A) The Health Plan shall complete and submit each report template 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) Any attachments included as part of the report shall be titled [Health Plan Name]_XXX_YYMM_Attachment where the word "Attachment" shall be replaced by more descriptive titles of the attachment included.

D) 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.

Report Section	Report Number	Report Name	Report Abbreviation	Reporting Frequency (ies)	Reporting Period(s)	Due Date(s)
Administration, Finances, and Program Integrity	101	Disclosure of Business Transactions and Ownership	ABT	Annually, Ad hoc	1/1-12/31	10/31 of proceeding year (Annual) Within 180 days of change in ownership (Ad hoc)
Administration, Finances, and Program Integrity	102	Medicaid Contract	MCR	Annually	7/1-6/30	12/31
Administration, Finances, and Program Integrity	103	Overpayments	OPR	Quarterly, Ad Hoc	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 60 days of identifying overpayment from DHS to health plan (Ad hoc)
Administration, Finances, and Program Integrity	104	Encounter Data/Financial Summary Reconciliation	EDR	Quarterly	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	11/30, 2/28, 5/31, 8/31
Administration, Finances, and Program Integrity	105	Medical Loss Ratio	MLR	Annually	1/1-12/31	10/31 of proceeding year
Administration, Finances, and Program Integrity	106	Fraud, Waste, and Abuse	FAS	Quarterly	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	108	Prescription Drug Rebates	PDR	Monthly, Annually	1/1–12/31 (Annually)	The last day of each proceeding month (monthly) 7/31 (Annually)
Administration, Finances, and Program Integrity	109	QUEST Integration Financial	QFG	Quarterly, Annually	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	110	Third Party Liability Cost Avoidance	TPL	Monthly, Quarterly	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)

						10/31, 1/31, 4/30, 7/31 (Quarterly)
Covered Benefits and Services	201	Community Integration Services	CIS	Quarterly	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	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30 (Quarterly) 10/1-9/30 (Annually)	10/31, 1/31, 4/30, 7/31 (Quarterly) 2/28 of the proceeding year (Annually)
Covered Benefits and Services	203	Long-Term Services and Support	LTSS	Quarterly	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	204	Home and Community Based Services Settings	HCBS	Quarterly	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	205	Special Health Care Needs	SHCN	Quarterly	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	206	Going Home Plus	GHP	Quarterly	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	11/31, 2/28, 5/31, 8/31
Member Services	301	Interpretation/ Translated Documents	ITR	Quarterly	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	302	1179	1179	Monthly		The 15th the Proceeding Month (Address, Phone, other)
Member Services	303	Call Center Report	CCR	Quarterly	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	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	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	1/1-12/31	10/31 of proceeding year
Provider Network / Services	403	Provider Network Adequacy Verification	PNA	Quarterly	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	PIE	Quarterly, Ad hoc	7/1-9/30, 10/1-12/31, 1/1-3/31,	10/31, 1/31, 4/30, 7/31 (Quarterly)

		Program Integrity Education			4/1-6/30 (Quarterly)	Within 3 days of suspension/ termination event (Ad Hoc)
Provider Network / Services	405	FQHC/RHC Services Rendered	FQH	Annually, Quarterly	1/1-12/31 (Annually) 7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30 (Quarterly)	5/31 of proceeding year (Annually) 11/31, 2/28, 5/31, 8/31 (Quarterly)
Provider Network / Services	406	Timely Access	TAR	Quarterly	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	501	Accreditation Status	ASR	Annually, Ad Hoc	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	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	Quarterly	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	504	Quality Assurance and Program Improvement	QAP	Quarterly	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	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	1/1-12/31	10/31 of proceeding year
Utilization Management	602	Drug Utilization Review	OUD	Annually, Quarterly	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	7/31 (Annually) 11/30, 2/28, 5/31, 8/31 (Quarterly)
Utilization Management	603	Prior Authorizations – Medical	PAM	Quarterly	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	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	1/1-12/31	5/31 of proceeding year

Utilization Management	606	Over-Utilization and Under-Utilization of Services	OUS	Quarterly	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	7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30	11/30, 2/28, 5/31, 8/31

E) All reports and supporting documentation shall be submitted electronically on SharePoint. Specific instructions can be found in the "QI HP Report Submission SOP."

F) Extension requests must be requested at least two business days in advance. Requests must be sent to mqdcmcs@hawaii.gov. DHS must approve the extension before the due date.

G) 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.

H) DHS may, at its discretion, require more frequent reporting by the Health Plan to provide accelerated monitoring as needed.

I) The Health Plan shall respond to DHS's request for any follow-up, actions, information, etc. as applicable per contract section 6.5.C.

Versioning and Adoption of New Versions

A) DHS may update any document within the reporting package include 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 document.

C) Documents that have undergone revision will have a version noted in the document name (v.x where x corresponds to the next

number revision). For example, an initial update to a report tool may have v.2 listed at the end of the name.

D) If there were no changes to any documents then Health Plans will continue to utilize the existing document.

E) 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 latest versions of the documents. Health Plans may transition to using the new version of any report tools earlier than 90 days.

DHS Review

A) DHS shall:

1. Review the Health Plan's report to assure contract compliance.

2. Review the Health Plan's KPIs to evaluate Health Plan performance for each reporting area.

3. Take follow-up action on any areas of concern observed in each report including any actions listed in specific 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_Worksheet" 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, in 1.B through 1.M. The worksheet will automatically calculate the percent of Total Award for each category, as well as the total of expenditures reported. Finally, the Health Plan shall enter the total gain or loss in 1.P.

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 employees (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. List categories and identify the number of employees per category during the reporting period.

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 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 or the name of the community event; a description of the contribution, cause, or community event; the total amount of the contribution in United States dollars; the % of total revenue; and whether the contribution is for QUEST only or for all lines of business.

c. The worksheet will automatically calculate the total dollars contributed to the community during the reporting period, and the total % of revenue.

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 % of revenue.

c. The worksheet will automatically calculate the total dollars spent during the reporting period on management and administrative contracts, and the total % of revenue.

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. Federal Adverse Actions: Number of federal Adverse Actions within the past five years.

2. State Adverse Actions: Number of 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.
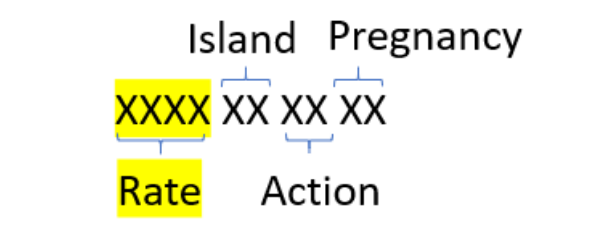
C) **Category of Service**:

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 three 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.

C) In **Section 2: Health Plan Overpayments to Providers Identified during Report Period** 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_PLDF_DataFormat 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.

2. 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.

D) In **Section 3: Health Plan Overpayments Review Process**, 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.

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 encounters adjusted and re-submitted to HPMMIS within 120 days of adjudication or adjustment of the claim.

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

103.6   Special Submission Instructions and Timelines for Submission

A) The Health Plan shall submit this report in two different ways:

1. If the Health Plan completes the report template as a 60 day notification to DHS of an Overpayment made to the Health Plan, the Health Plan shall complete Section 1: 60 Day Notification of

DHS Overpayments to Health Plans and the Attestation. The Health Plan shall then send the report to DHS.

   a. As a 60 Day Notification, the Health Plan shall submit this report to DHS within 60 days of discovering any instances of overpayments made to the Health Plan.

2. If the Health Plan completes the report as a quarterly report, the Health Plan shall complete Sections 2 and 3, as well as the Attestation, and send to DHS.

   a. As a quarterly report, the Health Plan shall submit this report to DHS no later than 30 calendar days after the end of each calendar quarter.

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. Number of CRNs; and

2. Amount of money Health Plans recorded spending on claims.

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 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 (Note: as of 10/2021, MQD only has two denial codes: H270 and H280)

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 extract from HPMMIS all paid encounters in their most recent adjudication status by each Health Plan with adjudication dates during the reconciliation period. DHS will _not_ include any of the following encounters in this extract:

1. Health Plan denied encounters

2. Health Plan voided encounters

3. Encounters that have been replaced by the Health Plan

   a. The replacement encounter will be included in the extract

B) DHS shall extract institutional encounters at the header level; all other encounters will be extracted at the line level

C) DHS shall extract two (2) data files from HPMMIS to provide to the Health Plans:

D) Line B "MQD extract" of the Summary tab of the EDFS_ALDF_MLDF report template, which summarizes 1) the total number of CRNs

and 2) the total paid amount for all CRNs, broken into a "Total" column and the following 6 categories of service:

1. Facility Inpatient – DRG Ineligible

1a. Facility Inpatient – DRG Eligible

2. Facility Outpatient

3. Professional/Other

4. Pharmacy

5. Nursing Home and Waitlist

6. Home and Community Based Services (HCBS)

E) A detailed extract file containing encounter line-level data for all encounters with Health Plan adjudication dates in the reconciliation period. The EDR_CLDF_FROM_MQD_DataFormat file lists the field formats and definitions the MQD will provide Health Plans during reconciliation. DHS 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 where Health Plan ID is "XALOHA".

F) DHS shall send each Health Plan their extracted HPMMIS data as well as the EDR Reconciliation Report template with Line B completed using the State sftp.

G) The Health Plans shall then extract data based on paid claims submitted to DHS as of the date DHS extracted data from HPMMIS. The Health Plans shall _not_ include any of the following claims in their extract:

1. Health Plan denied claims

2. Health Plan voided claims

3. Claims that have been replaced by the Health Plan in HPMMIS

   a. The replacement claim will be included in the extract

H) Health Plans shall complete the Summary tab of the EDR Reconciliation Report template, as well as the Breakdown crosstabs on the Summary tab as well. The Breakdown crosstabs summarize the Total Paid Amount and Total Number of CRNs where:

1. HPMMIS and the Health Plan data match (D)

2. HPMMIS and the Health Plan data don't match (E)

   a. 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 E will sum all of these values for a net total.

3. HPMMIS has data the Health Plan does not (F)

4. The Health Plan has data but it is not in HPMMIS's data because it pended (G1)

5. The Health Plan has data but it is not in HPMMIS's data because it denied(G2)

6. The Health Plan has data but it is not in HPMMIS's data because it rejected (G3)

7. The Health Plan has data but it is not in HPMMIS's data because the Health Plan did not submit it (G4)

8. The Health Plan has data but it is not in HPMMIS's data where the Health Plan believes DHS accepted the data but it is not present for an unknown reason (G5).

I) 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.

J) The Health Plan shall complete the crosstab on the Summary tab of the EDR Reconciliation Report and shall provide .CSV extracts of the data defined in lines D, E, F, G1, G2, G3, G4, and G5 in the remaining tabs. Each tab between D and G4 will ask for the following pieces of information about the claim:

1. Form Type

2. Category (Facility Inpatient, Facility Outpatient, Professional/Other, Pharmacy, Nursing Home and Waitlist, Home and Community Based Services)

3. Claim Number (from the Health Plan data, if applicable)

4. CRN (from the DHS extract, if applicable)

5. Date of Service

6. HP Paid Amount (from the DHS extract, if applicable)

7. MCO Paid Amount (from the Health Plan extract, if applicable)

8. Rejection/Denied/Pended Code (if applicable)

9. Rejection/Denied/Pended Reason (if applicable)

10. Reason not submitted (if applicable)

K) The Health Plan shall provide additional information on the ledger paid amounts during the reconciliation period, and the amounts included in the reconciliation process.

1. Report the Health Plan's total ledger paid amount for benefit expenses during the reconciliation period. 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 our actuaries.

2. Report the Health Plan's ledger paid amount that was included in the reconciliation process completed in Section I. This amount should align with what was reported in Line A of the EDR_MLDF_ALDF.

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. 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 3 must add up to the difference between the values reported in Questions 1 and 2. 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 3.

L) In **Section 2**, the Health Plan shall submit a variety of metrics tied to encounter data completeness and timeliness during the reporting period.

1. The Health Plan 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 where the Health Plan made a payment

b. Adjudicated valid claims that the Health Plan denied

c. Adjudicated valid claims that the Health Plan adjusted

d. Adjudicated valid claims that the Health Plan identified as Overpayments that the Health Plan did not adjust

e. Adjudicated valid claims where the Health Plan determined that no Medicaid liability exists/no Medicaid payment shall be made

f. Adjudicated valid claims for Health Plan value-added services

2. The Health Plan shall report on services rendered by Health Plan or Health Plan delegated personnel. Here, the Health Plan shall report on services that are delegatable to community providers, but the Health Plan has chosen to perform internally (e.g. service coordination, care coordination, housing coordination, case management, outreach efforts, medication reconciliation, and quality improvement activities). The Health Plan shall bucket these types of services provided into one of the types of services, and identify the number of services provided, costs of these services, the number of these internal services that were captured as claims and submitted as encounters to DHS.

3. The Health Plan shall report on the claims that were adjudicated by categories of services defined in this report during the reporting period, and identify how many of these were submitted to DHS.

4. The Health Plan shall focus on claims with service dates older than 15 months prior to the first date of the reporting period. The Health Plan shall parse these claims by categories of services defined in this report and identify how many of these

were adjudicated, how many of those adjudicated were submitted as encounters, and how many claims have not yet been adjudicated by the Health Plan.

    a. If the Health Plan has not submitted all claims with service dates older than 15 months prior to the first date of the reporting period that were adjudicated during the reporting period as encounters, the Health Plan shall list these 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.

1. Variance between Health Plan and Encounter Data – Total ($)

2. Variance between Health Plan and Encounter Data – Facility Inpatient DRG Ineligible ($)

3. Variance between Health Plan and Encounter Data – Facility Inpatient DRG Eligible ($)

4. Variance between Health Plan and Encounter Data – Facility Outpatient ($)

5. Variance between Health Plan and Encounter Data – Professional/Other ($)

6. Variance between Health Plan and Encounter Data – Pharmacy ($)

7. Variance between Health Plan and Encounter Data – Nursing Home/Waitlist ($)

8. Variance between Health Plan and Encounter Data – Home and Community Based Services ($)

9. Percent of the total ledger paid amount used in the reconciliation process

10. Percent of the total ledger paid amount not submitted as encounters during the reporting period

11. Percent of services rendered by Health Plan personnel that were submitted as encounters

12. Percent of encounters submitted by the Health Plan of all claims adjudicated during the reporting period

13. Percent of claims with service dates older than 15 months that have been adjudicated

14. Percent of claims with service dates older than 15 months that have been submitted as encounters

104.6   Special Submission Instructions and Timelines for Submission

A) The Health Plans shall submit two types of files to DHS:

B) The Health Plan shall provide the completed EDR Reconciliation Report template as an Excel file uploaded to DHS's sftp site;

C) The Health Plan shall provide supporting extracts for tabs D through G4 by uploading each extract as a .CSV to 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

Integration program. However, the majority of the items explicitly requested to be quantified on a subsequent line in this report are not supposed to be reported on Line (A).

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.

4) 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.

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

5) Line C: Withholds from payments made to network providers.

6) 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.

7) 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.

8) 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.

9) Line G: Changes in other claims-related reserves.

10) 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% - Adjusted MLR) X (Premium Revenue – Taxes and Fees). Any positive values indicate that the Health Plan owes a remittance to DHS.

105.4   Methodology

A) The Health Plan shall complete the Data Collection tab in the attached MLR Report template.

   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. The formula used to calculate Medical Loss Ratio is:

$$MLR = \frac{Incurred\ Claims + Quality\ Improvement}{Premium\ Revenue - Taxes\ and\ Fees}$$

$$Adjusted\ MLR = \frac{Incurred\ Claims + Quality\ Improvement}{Premium\ Revenue - Taxes\ and\ Fees} + Credibility\ Adjustment$$

G) The Adjusted MLR value will be used to determine whether the Health Plan shall owe a Remittance to DHS.

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) **Overpaymen**t: 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 three sections:

1. 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:

a. The Name and Contact Information of the Health Plan's Compliance Officer

b. The Name(s) and Contact Information of the Health Plan's Compliance Committee members

c. 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.

d. The Health Plan shall attest to whether their Compliance Committee met during the reporting period to discuss FWA compliance issues.

e. If the Compliance Committee did meet, the Health Plan shall attach a copy of that meeting's agenda to the report.

f. The Health Plan shall attest to whether any updates were made to the Health Plan's FWA Compliance Plan since the last reporting period.

g. If updates were made, the Health Plan shall attach a copy of the most up-to-date version of the FWA Compliance Plan.

B) 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.

C) 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 Control Unit (MFCU) trainings, webinars, or other trainings on FWA detection and investigation activities;

2. A list of specific activities the Health Plan has conducted to review providers' provision of services during the reporting period;

D) 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.

E) **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.

F) 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 108:   PRESCRIPTION DRUG REBATES

108.1   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.

108.2   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).

108.3   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/Drug-Pricing-and-Payment/Drug-Products-in-the-Medicaid-Drug-Rebate-Program/v48d-4e3e/data.

B) **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.

C) **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.

D) **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.

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

108.4   Methodology

A) This report is organized into three sections:

1. Section 1: Medicaid Drug Rebate Program

2. Section 2: Assessment of Methods used to pull drug extracts

3. Section 3: Annual Drug Rebate Summary

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.

108.5   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

4. Percent of Rebate Units present in the Medicaid Drug Rebate Program extract that were not converted

REPORT 109:   QUEST INTEGRATION FINANCIAL

109.1   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.

109.2   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.

109.3   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%.

109.4   Methodology

A) This report is organized into three sections:

1. 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:

   a. Total adjusted capital, post-tax

   b. Authorized Control Level = 100% of Authorized Control Line

   c. Total Revenue

   d. Underwriting Deductions

   e. Combined Ratio

   f. RBC Ratio

2. 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.

B) 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.

C) In **Section III: Protected Health Information Breaches**, the Health Plan shall report if they identified any breaches of individual's 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.

109.5   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 110: THIRD PARTY LIABILITY COST AVOIDANCE

110.1 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.

110.2 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.

110.3 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 the quarter (e.g., maximum of three months per member). This number 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

110.4 Methodology

A) This report is organized into several sections.

1. 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. The Health Plan shall provide the following summaries:

a. For Coordination of Benefits Collections:

1) Total Collections Amount

2) Total Cost Avoided Amount

    b. For Accident Liability Recoveries:

       1) Total Collections Amount

          i. Note, DHS shall be responsible for coordination and recovery of accident and worker's compensation subrogation benefits.

       2) Total Cost Avoided Amount

2. 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:

    a. TPL Status

    b. Category of Service

    c. Rate Code Group

3. 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:

    a. A list of all active members who have commercial insurance with the same or other health plans.

    b. 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.

4. 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. A list of all active members who have commercial insurance with the same or other health plans.

b. For definitions of fields in the reporting template for Section 3, refer to the "TPL_MLDF_2_DataFormat" in this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder.

110.5 Key Performance Indicators (KPIs)

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

1. Cost Savings for Facility Inpatient services
2. Cost Savings for Facility Outpatient services
3. Cost Savings for Professional/Other services
4. Cost Savings for HCBS services
5. Cost Savings for Pharmacy services
6. Cost Savings for Nursing Home/Waitlist services

REPORT 201: COMMUNITY INTEGRATION SERVICES

201.1   Introduction

A) The purpose of this report is to monitor the Health Plan's provision of Community Integration Services (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 3.7 provides a description of Health Coordination Services the Health Plan should provide for members that meet the CIS criteria.

B) Section 4.7 provides coverage provisions for Community Integration Services including pre-tenancy supports and tenancy sustaining services.

C) Section 5.1.A.4 notifies the Health Plan of the requirement to participate in the Rapid Cycle Assessment of the CIS program.

D) Section 6.2.E.2 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**: 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.

201.4   Methodology

A) This report is organized into two sections.

1. In Section 1, the Health Plan shall provide a data file that contains three datasheets: the Aggregate-Level Data File (ALDF), the Aggregate Level Data File Progress Sheet, and the Member-Level Data File (MLDF). This file will be called the ALDF-MLDF Combined Data File.

2. In Section 2, the Health Plan shall provide the CIS Qualitative Data Collection Component (QDCC).

B) Data Sources:

1. The Health Plan will report aggregate and 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. These include:

   a. CIS Referral Form

   b. CIS Consent and Member Demographic Form

   c. CIS Member Assessment/Re-Assessment Tool

   d. CIS Health Action Plan Addendum

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 report shall include all members that were active at any time during the reporting period. The report shall exclude services related to Member enrollment in Long Term Services and Supports and Special Health Care Needs.

2. In **Section 1**, the ALDF-MLDF Combined Data File will include the ALDF, which will use administrative and encounter data collected by the Health Plan and data aggregated from the

Member-Level Data File (MLDF). The Health Plan should enter the numeric data into the "value" column next to each metric in the ALDF datasheet. Where applicable, the ALDF contains formulas in the "MLDF Calculation" column that populate data from the MLDF. Health Plans may use this calculation to cross-check their data entry. The column "Health Plan Notes" may be used to indicate reasons for discrepancies.

a. All aggregate metrics in the ALDF shall be focused on activities conducted during the reporting quarter, unless otherwise specified. For example, "Members newly identified by data analytics as potentially eligible for CIS (internal referrals)" shall be limited to the Health Plan's members who were newly identified via data analytics as potentially eligible for CIS during the reporting period.

b. Unplanned hospital admissions are defined using 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.hcup-us.ahrq.gov/tools_software.jsp

   1) For a reference document and tables identified in the methodology below please refer to "Reference Tables and Data Submission.xlsx" in this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder.

   2) The planned admission algorithm follows two principles to identify planned readmissions:

i. 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).

ii. 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).

iii. Tables B1, B2, B3 and B4 are provided in the reference tables document to support the health plan in identifying planned admissions.

iv. Once planned admissions are identified, Unplanned admissions = All Admissions - Planned Admissions

c. Metrics are based on monitoring for program activities. Categories for program activity metrics include:

i. Member Screening for Eligibility

ii. Eligibility Confirmation

iii. CIS Enrollments

iv. Disenrollments

v. New Member Assessments

vi. Re-Assessments

vii. CIS Services and Support Needs

viii. Health Coordination Services Received

ix. Supports for Medicaid Eligibility

x. Data Sharing

xi. Outcomes

d. The ALDF Progress Sheet includes 21 Aggregate Metrics that will be populated automatically using numbers entered for the previous metrics in the ALDF.

e. All metrics in the categories "Member Screening for CIS Eligibility" and "Eligibility Confirmation" shall be based on the Health Plan's total membership, and all incoming newly enrolled members.

f. For all metrics in the remaining categories (i.e., CIS Enrollments, CIS Disenrollments, New Member Assessments, Re-Assessments, CIS Services and Support Needs, Health Coordination Services Received, Supports for Medicaid Eligibility, Data Sharing, and Outcomes) the Health Plan shall report totals only for members in CIS.

g. "Members identified by any method" as potentially eligible for CIS include members identified via data analytics, new member survey/welcome call, quality improvement initiative, any type of referral (i.e., provider, self, or other referral), or other means.

h. For members potentially eligible who have not been reached to participate, "reached" means in person or phone contact with the member for confirmation of eligibility and participation.

i. When the data requested is specific to "Existing CIS members", the Health Plan shall provide information on existing CIS members who were enrolled and receiving CIS services prior to the start of the reporting period.

j. New CIS members who were enrolled in CIS services during the reporting period shall NOT be included. The two

populations (New CIS Members and Existing CIS Members) in the ALDF are designed to be mutually exclusive.

k. Number of existing CIS members on the first day of the reporting period is the total enrollment of CIS members as of the first day of the reporting period.

l. Number of existing CIS members on the last day of the reporting period is the total enrollment of CIS members on the last day of the reporting period, excluding the new CIS Members. This number may be lower than the number of existing CIS members on the first day of the reporting period if some CIS members were disenrolled within the reporting period.

m. Existing CIS members who were overdue for a re-assessment/plan review and update on the first day of the reporting period includes members whose most recent assessment (either initial assessment or re-assessment) and/or CIS Health Action Plan Addendum (either initial plan or review and update) was completed earlier than the prior reporting quarter.

n. Existing CIS members that completed a re-assessment/plan review and update includes all CIS members who completed a re-assessment, plan review, and update within the reporting period.

o. For indicators under the category of "CIS Services and Supports Needs," the Health Plan shall count CIS members who are either new or existing for whom one need has been identified, regardless of whether the need was identified during the reporting quarter as long as the need is active during the reporting quarter.

p. 'Average number of face-to-face hours per member per month among members enrolled in CIS and actively receiving services' shall be calculated based on CIS members actively enrolled in CIS (i.e. members who have completed their consent to participate in the program, and who have not been lost to follow up or disenrolled).

q. For the purposes of this report, any office visit the member has with their PCP is classified as a "routine check-up."

r. To support Health Plans with accurate completion of the ALDF, please refer to the "CIS ALDF H-Code Mapping" tab in the "Reference Tables and Data Submission.xlsx" in this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder. This tab provides information on how CIS status codes assigned to members maps to reporting requirements in the ALDF.

s. Additional guidance on ALDF data fields can be found in the "CIS ALDF Guidance" tab of the "Reference Tables and Data Submission Format" file.

3. The Member-Level Data File (MLDF) will use be used to evaluate CIS member outcomes by assessing member-level data and can be used to calculate member-specific ALDF metrics.

a. When reporting data in the MLDF, Health Plans should follow guidance for naming each variable and coding responses using the reference table found in the "MLDF Data Submission Format" tab of the "MLDF Reference Tables and Data Submission Format" file.

b. The "MLDF Data Submission Format" tab of the "Reference Tables and Data Submission Format" file provides data

source, formatting, description, and coding information for each MLDF data field

c. The primary data sources for the MLDF are the "CIS Referral Form," "CIS Consent and Member Demographic Form," "CIS Health Action Plan Addendum" and "CIS Member Assessment/Re-Assessment Tool" which can be found in this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder. For clarity, fields in the CIS Consent and Member Demographic Form, CIS Health Action Plan Addendum and CIS Member Assessment/Re-Assessment Tool that will be reported in the MLDF are highlighted in the document below, along with the variable names and codes for responses.

d. Missing data: For the MLDF, there may be instances of missing data. In these cases, the Health Plan should use the indicator "-999". If the data field is N/A, then leave it blank, except for in specified rows where it is indicated to use the indicator "-99" (e.g., for the "DISENROLL_REASON" variable, the Health Plan should use -99 to indicate that the member is not disenrolled). Please do not enter 0 for missing or N/A data.

e. For the MLDF, Health Plans should report any new and current data available for that reporting period. For example, if a CIS Assessment was not completed during the quarter for the member, the fields in the MLDF corresponding to the CIS Assessment will contain -99. However, any data from other sources (such as the Health Action and Service Plan) should be filled in.

f. Generally, it is expected that all data will be reported in the same quarter they were collected. However, there may be rare instances in which the data were collected and not reported in the same quarter. For example, data may have been collected at the end of quarter 3 of a given year and reported in quarter 4 of the same year because they were collected very close to the deadline. To address this, the variable "ASSESS_YEARQTR" indicates the year and quarter that the data were collected. Please use the four-digit year and the quarter number (e.g., 20221, 20222, 20223, 20224). In the example above, the assessment data would be reported in quarter 4, and the variable ASSESS_YEARQTR would be 20223. In this instance, if the assessments are completed on time, the member may have two rows of data within that reporting period – one from quarter 3 and one from quarter 4.

4. 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 can 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 supports.

2. Percent of members potentially eligible for CIS identified through Health Plan analytics and internal referrals.

3. Percent of members with eligibility confirmation within the allowed window (15 days for external referrals; 30 days for internal referrals).

4. Percent of members who consented to participate in CIS within 10 days of eligibility confirmation.

5. Percent of members who declined participation in CIS.

6. Percent of new CIS members who completed their initial assessment within 15 days of consent.

7. Percent of existing CIS members who received a CIS Re-Assessment/Plan Review and Update within 90 days.

8. Percent of CIS members who were due for Medicaid eligibility re-determination who remained in Medicaid on the last day of the reporting period.

9. Percent of CIS members who transitioned from pre-tenancy to tenancy.

10. Percent of CIS members who were lost to follow up.

11. Percent of CIS members whose Assessments/CIS Health Action Addenda were shared with their PCP.

12. Percent of CIS members who have not had a routine check-up within the past year.

13. Percent of CIS members with two or more unplanned hospitalizations.

14. Percent of CIS members with two or more ER Visits.

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) **Quarterly State Periodicity Schedule**: This is equal to the State Periodicity Schedule divided by the number of years in an age group then divided by four.

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 Quarterly State Periodicity Schedule (E) (for Quarterly Reports) or Annual State Periodicity Schedule (D) (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, HIPP 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.

202.4 Methodology

A) The Health Plan shall complete the Data Collection worksheets embedded in the Report.

B) There are separate reporting templates for quaterly (Section I) and annual (Section II) submissions.

C) 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. In Cell B2-C2 enter the reporting period (e.g., 1/1/2021 – 3/31/2021, or 10/1/2020-9/30/2021) for each of the islands.

D) All measures are disaggregated by eligibility status (i.e., Categorically Needy and Medically Needy) and age group (e.g, <1 years).

E) 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 203:   LONG-TERM SERVICES AND SUPPORTS

203.1   Introduction

A) The purpose of this report is to monitor the Health Plan's provision of Long Term Supports and Services (LTSS). The data gathered will be used to assess quality of services provided, contract compliance, and evaluation of health outcomes associated with engagement.

203.2   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, HCBS, NF LOC).

D) Section 6.2.E.2 (Covered Benefits and Services) includes the LTSS report.

203.3   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) **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.

D) **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."

E) **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.

F) **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).

G) **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, instead of living in an institutional facility.

H) **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.

I) **Health and Functional Assessment (HFA):** refers to the Health Plan's collection of health status, health conditions, social risk factors, and other information, and is also described generally as the "assessment" or "re-assessment". It has been referred to as the Functional Needs Assessment in previously circulated documents.

J) **Health Action Plan (HAP):** refers to a person-centered, individualized plan that is based on the Health and Functional Assessment. It describes the medical, behavioral, and social needs of the member, and creates a plan for service provision. The HAP has been referred to as the Individualized Service Plan, and the Individualized Plan in previously circulated documents.

203.4   Methodology

A) This report is organized into four sections.

1. Section 1: A Services and Authorizations File that focuses on data gathered in the prior LTSS report on explanations for assessment plans or service plans not completed within the required timelines, additional authorized services, reductions in authorized services, authorization approvals for EAA, SME and Moving Assistance, and adverse events reports for LTSS members.   The format for data collection remains identical to the previous LTSS report.

2. Section 2: An Aggregate-Level Data File (ALDF) to evaluate and monitor service provision;

3. Section 3: A Member Level Data File (MLDF) to evaluate member-level outcomes and capture improper payments claims; and

4. Section 4: Additional qualitative questions to evaluate LTSS services, particularly initiatives to move waitlisted members into suitable, permanent care.

B) Data Sources:

1. The Health Plan will report aggregate and member-level data from a number of sources. In addition to administrative records, LTSS-specific sources for each metric are included in the MLDF. These include:

    a. DHS 1147 Level of Care and At-Risk Evaluation Form; and

    b. Health and Functional Assessment (HFA)

C) For reference tables to aggregate and group data for reporting, as well as the data submission format for the submission of the member-level data file, please refer to "Reference Tables and Data Submission.xlsx" in this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder.

1. The tab "HCBS Services Reference" provides procedure codes included as part of QI HCBS services.

2. The tab "NH Code-MLTSS-Setting-LOC" provides a comprehensive crosswalk of Nursing Home Code to Setting (Nursing Home (NH), Home and Community Based Services (HCBS), Sub-Acute (SA) and Waitlist (WL), and Level of Care (i.e. those codes that are indicative of services provided at the Nursing Facility (NF) LOC). This table allows members to be parsed by various LTSS sub-groups as required for reporting. A

given member's LOC code (a.k.a. nursing home code) may be found on the Health Plan's 834 file submission, in Loop 2300, Element HD04.

3. The tab "MLDF Data Submission Format" contains the member-level data file submission formats.

D) Data Collection/Reporting:

1. Each report shall provide updates on all LTSS activities the Health Plan has undertaken during the reporting period. Each report shall also provide the Health Plan's ongoing and future efforts to enhance the implementation of LTSS programs.

2. In **Section 1**, the Health Plan shall report data in tabs "A. Assessment & Service Plan," "B. Additional Auth by Member," "C. Reduction Auth by Member," "E. Auth Approvals," and "G. AER" exactly as reported in previous LTSS reports.

3. In **Section 2**, the ALDF will primarily use administrative and encounter data collected by the Health Plan. The Health Plan should enter the numeric data into the "value" column next to each metric in the ALDF datasheet.

    a. For the "Enrollment, Assessment, and Planning" and "HCBS Services" tabs in ALDF, please report data only for activities conducted during the reporting quarter, unduplicated across members. For the "MOE" tab, please only report based on paid claims dates that fall in the reporting period.

    b. Metrics are based on monitoring for program activities.

    c. The aggregate data file contains three tabs:

        1) Enrollment, Assessment, and Planning;

        2) HCBS Services; and

        3) MOE

d. The Enrollment, Assessment, and Planning section of the report will assess the Health Plan's activity related to confirming the eligibility of new LTSS members, enrolling members in services, assessing and re-assessing member needs in an appropriate time frame, considering member choice in their care experience alongside appropriate care settings, data sharing, changes in setting and level of care among LTSS members, the number of waitlisted members at various time points during the reporting period, and members transitioned off of the waitlist. Within Enrollment, Assessment, and Planning, specific activity metrics including those related to:

1) Eligibility Confirmation

2) Enrollment in LTSS

3) Assessments/Re-Assessments

4) Initial Health Action Plan / HAP Review and Update

5) Member Choice/Initial Setting

6) Self-Directed Care

7) Data Sharing

e. The HCBS Services section of the report heavily relies upon the "HCBS Services Reference" tab.

1) This section assesses HCBS services authorized for and provided to HCBS receiving populations, including both members who are classified as "At-Risk" and who meet criteria for NF LOC but have chosen to receive HCBS.

2) Members should be unduplicated within each HCBS Service Category. For example, if a member received three different services that fall under the category of "Personal assistance (Agency)", they would still be counted one time

only to indicate that that member received personal assistance during the quarter.

3) Members with increases and decreases in authorizations for services across HCBS Service Category compared to the prior reporting quarter should also be reported.

4) Within HCBS Services, specific activity metrics include reporting on each individual HCBS Service category among At-Risk, and NF LOC groups, as well as expenditures on each HCBS service category.

f. The "MOE" tab is similar to the "HCBS Services" tab except that Health Plans will report total expenditures by category and unduplicated members based on paid claim dates that fall within the reporting period, not service date.

g. It should be noted that within the HCBS Services and MOE sections of the report, "At-Risk" and "HCBS meeting NF LOC" groups should be mutually exclusive groups, as defined by member status on the last day of the reporting period such that, when combined, they equal the total number of unique members receiving any HCBS services.

h. Several summary metrics in each of the two categories listed above (Enrollment, Assessment, and Planning; and HCBS Services) will be populated automatically using numbers entered within the report.

4. In **Section 3**, the MLDF will be used to evaluate LTSS member outcomes by assessing member-level data.

a. When reporting data in the MLDF, Health Plans should follow guidance for naming each variable and coding responses using the "MLDF Data Submission Format" tab.

b. One of the primary reference sources for the MLDF is the Health and Functional Assessment (HFA). For clarity, for fields in the HFA that will be reported in the MLDF, along with the variable names and codes for responses, please refer to "HFA_LTSS MLDF Field Mapping.docx" in this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder.

c. Missing data: For the MLDF, there may be instances of missing data. In these cases, the Health Plan should use the indicator "-999". If the data field is N/A, then leave it blank, except for in specified rows where it is indicated to use the indicator "-99" (e.g., for the "Need Childcare" variable, the Health Plan should use -99 to indicate that the member does not have children). Please do not enter 0 for missing or N/A data.

d. For the MLDF, Health Plans should report any new and current data available for that reporting period. For example, if a HFA was not completed during the quarter for the member, the fields in the MLDF corresponding to the HFA will be left blank (or -999 if the assessment was completed, but not all data fields were collected). However, any data from other sources collected during the quarter should be filled in.

e. Generally, it is expected that all data will be reported in the same quarter they were collected. However, there may be rare instances in which the data were collected and not reported in the same quarter. For example, data may have been collected at the end of quarter 3 of 2022 and reported in quarter 4 of 2022 because they were collected very close to the deadline. To address this, the variable

"ASSESS_YEARQTR" indicates the year and quarter that the data were collected. Please use the four-digit year and the quarter number (e.g, 20221, 20222, 20223, 20224). In the example above, the assessment data would be reported in quarter 4, and the variable ASSESS_YEARQTR would be 20223. In this instance, if the assessments are completed on time, the member may have two rows of data within that reporting period – one from quarter 3 and one from quarter 4.

f. Under "HOSPITALIZATION," the Health Plan shall report acute hospitalizations. Under "INSTITUTIONALIZATION," the Health Plan shall report on any stay in an institutional setting. Under "TRANSITION_CARE_SETTING," the Health Plan shall report on any transitional care provided following changes in major settings, such as transitions from institutionalization to community living or from one institutional setting to another (e.g. WL to NF, NF to HCBS, HCBS to NF, NF to Acute, Acute to ICF/SNF, etc.).

g. Where asked about the length of stay in a particular setting (e.g. institutional, waitlist, etc.), and in cases where a given stay cuts across two reporting quarters, the Health Plan shall report the stay in both quarters. In these instances, the length of stay for each quarter shall be appropriately partitioned. In other words, the Health Plan shall report the number of days between the start of the stay and the end of that quarter for the first quarter, and the number of days from the start of the new quarter to the last day of the stay for the second quarter.

h. The last column in the "MLDF Data Submission Format" tab of the "MLDF Reference Tables and Data Submission Format" file provides variable matching from the MLDF to the ALDF.

5. In **Section 4**, the Health Plan shall qualitatively describe its efforts to support rebalancing its LTSS members towards greater utilization of HCBS, and its strategies to transition members off the waitlist.

203.5 Key Performance Indicators (KPIs)

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

1. Percent of New LTSS Members who completed their initial assessment within 15 day of eligibility confirmation

2. Percent of Existing LTSS Members overdue for reassessment as of the last day of the reporting period

3. Percent of Existing LTSS Members whose most recent HAP was comprehensively updated within 12 months of the last day of the reporting period

4. Percent of New LTSS Members meeting criteria for NF LOC who choose to receive HCBS

5. Percent of Self-Directed Services Providers employed by the Health Plan who were provided with the required training

6. Percent of New and Existing LTSS Members whose HAP were shared with their PCP

7. Percent of New and Existing Members transitioned off the waitlist at any point during the reporting period

8. Percent of At-Risk members receiving non-At-Risk HCBS services (i.e. HCBS services that are not allowed for At Risk members)

9. Percent of HCBS members meeting NF LOC receiving authorized HCBS services

10. Average percent of members across At-Risk and HCBS members meeting NF LOC groups (combined) receiving authorized HCBS services

REPORT 204:   HOME AND COMMUNITY BASED SERVICES SETTINGS

204.1 Introduction

A) The purpose of the Home and Community Based Settings (HCBS) Settings Report is to monitor and evaluate the Health Plan's implementation of requirements around HCBS settings, providers, and health action plans.

204.2 Applicable Contract and Health Plan Manual Sections

A) Section 3.7.D (Health Plan Responsibilities for SHCN, EHCN, and LTSS) outlines HCBS benefit requirements per 42 CFR §441.301, §441.302, and §441.710(a)(1).

B) Section 4.8 (Coverage Provisions for Long-Term Services and Supports) describes the coverage provisions for HCBS.

C) Section 6.2.E.2 (Covered Benefits and Services) outlines the required Home and Community Based Services settings report to DHS per 42 CFR §438.330.

204.3 Terms and Definitions

A) N/A

204.4 Methodology

A) This report is organized into two sections.

1. In **Section I: Member- and Provider-level Data File** the Health Plan shall report on every metric within the data file for the past quarter be referring to "HCBS_MLDF_DataFormat" in

this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder. Each of the four separate tabs correspond to each of the four tabs in the member- and provider-level data file.

2. The Health Plan shall provide the following member- and provider-level data for each of the following four tabs:

   a. Provider tab: The Health Plan shall gather together a list of all HCBS providers. This includes providers in any of the following provider types who provide HCBS services to members.

Provider Type	Description	Category
22	Nursing Home	Nursing Facilities
23	Home Health Agency	Home Health Agencies
24	Personal Care Attendant	Personal Care Assistance Providers
27	Adult Day Health	Adult Day Health Centers
28	Non-Emergency Transportation	Non-Emergency Transportation Providers
30	DME Supplier	DME Providers
34	Case Management Services	CCMAs
36	Assisted Living Home/HCBS	Assisted Living Facilities
46	Nurse (Private – RN/LPN)	Private Duty Nurses
49	Assisted Living Center – Units Only	Assisted Living Facilities
50	Adult Foster Care	CCFFHs
70	Home Delivered Meals	Home Delivered Meals Providers
96	Non-Emergency Transportation (Recip)	Non-Medical Transportation Providers
A7	RESPITE (FOR MQD ONLY)	Respite Care Facilities

   b. These providers shall be cross-walked by the Health Plan to the "HCBS Provider Type" applicable to the current report.

      1) 01 = ALF

      2) 02 = CCFFH

      3) 03 = E-ARCH

      4) 04 = Adult Day Care

      5) 05 = Adult Day Health

      6) 06 = Community Case Management

7) 07 = Counseling and Training

8) 08 = Non-medical Transportation

9) 09 = Personal Assistance Services

10) 10 = Respite Care

11) 11 = Skilled Nursing Facility

12) 12 = Private Duty Nursing

c. If a given provider could be grouped into multiple categories (e.g. a HCBS provider offers both community case management and skilled nursing services), up to three HCBS Provider Type variables are available for the Health Plan's use. If a provider offers more than three types of HCBS services, the Health Plan shall choose the three most predominant services offered by the provider. Each provider shall be listed once in the file.

d. In the provider tab:

1) Provider's legal name in "Provider_Name."

2) The Medicaid Provider ID is reported in "Medicaid_Provider_ID"

3) The Medicaid Provider Type shall be reported in "Medicaid_Provider_Type." The provider type categories are listed in the data file format file.

4) The island(s) on which the providers deliver services will be reported in "Provider_Islands_Service." If providers deliver services on multiple islands during the reporting period then they will report each one.

5) The provider's status (e.g., new or existing) will be reported in "Provider_Status".

6) The date the provider's application was received shall be reported in "Application_Date".

7) The date the provider was credentialed in "Provider_Credentialed_Date."

8) The date the provider's contract started will be reported in "Provider_Contract_Date."

9) The date the provider started HCBS services will be reported in "Services_Delivery_Date."

10) If the provider received any training on how to identify, address, and seek to prevent Abuse/Neglect/Exploitation/Death (A/N/E/D), then it will be reported in "Provider_Training_AE."

11) The number of employees of the provider that deliver HCBS services will be reported in "Provider_Employees_Number". If the provider is the sole employee then the number of employees is equal to one.

12) The number of recently hired "new" employees of the provider that deliver HCBS services will be reported in "Provider_Employees_New."

13) The number of employees who deliver HCBS services to members and met training requirements prior to delivering services will be reported in "Provider_Employees_Training."

14) The number of new employees who deliver HCBS services to members and met training requirements prior to delivering services will be reported in "Provider_Employees_New_Training."

15) The date self-directed providers fulfilled training requirements prior to delivering services will be reported in "SD_Provider_Training."

e. Member Tab: All members receiving HCBS services during the quarter, including both At Risk members and those meeting Nursing Facility Level of Care shall be included here. In addition to HAP dates, service dates, and other administrative data, the Health Plan is expected to capture data electronically on any prohibitive restrictive interventions applied to members, as well as member training on identifying, addressing and seeking to prevent abuse, neglect, exploitation, and death (A/N/E/D) events, for all members receiving HCBS.

1) The member's legal name will be reported in "Member_Last_Name" and "Member_First_Name."

2) The member's Medicaid ID will be reported in "HAWI_ID."

3) The member's "HCBS Status" identifies whether the member was "At Risk" or meeting "Nursing Facility Level of Care (NF LOC)" as of the last date of the reporting period.

4) The member's initial level of care (LOC) date will be reported in "Initial_LOC_Date." For "At Risk" Members, note the first date that At Risk services were approved.

5) The date the member first began receiving HCBS services will be reported in "HCBS_Start_Date."

6) The date the member received the most recent LOC determination will be reported in "Recent_LOC_Date." For "At Risk" Members, note the most recent At Risk determination/redetermination date.

7) The method of LOC submission will be reported in "LOC_submission_type" to capture if LOC was submitted electronically via the HILOC database, or via a hard copy 1147 form that was faxed or mailed for review.

8) If the member experienced a service interruption type since beginning to receive HCBS services it will be reported in "Service_interruption."

9) The first date since service interruption that the member began to receive HCBS services. If multiple interruptions, then the most recent service renewed date will be reported. If no service interruption, then the Health Plan shall leave that field blank.

10) If the member received any training on how to identify, address, and seek to prevent A/N/E/D then it will be reported under "Training_AE."

11) The date the member received training on how to identify, address, and seek to prevent A/N/E/D will be reported under "Training_AE_Date." If no training, then the Health Plan shall leave blank.

12) If the member had a health action plan then it will be reported under "Health_Action_Plan."

13) If the member was randomly selected for a health action plan review, then it will be reported under "Member_HAP_Review." Please find details on the protocol for how the random selection should be completed later in this report methodology.

f. Health Action Plan (HAP): The Health Plan shall conduct a detailed audit of the randomly selected HAPs in each quarter to identify the following. Data reported in this section shall

be limited to those HAPs randomly selected for the HAP audits.

1) The Member's legal name will be reported under "Member_Last_Name" and "Member_First_Name."

2) The Member's Medicaid ID will be listed under "HAWI_ID."

3) The data the member's HAP was renewed will be reported under "HAP_Renewed_Date."

4) If it has been more than a year since the HAP (365 days) had been renewed at time of report submission, then the Health Plan shall describe why there was a delay.

5) If the member's HAP contains a contingency plan for emergencies it will be reported under "Emergency_Plan."

6) The Health Plan will then report if the contingency plan for emergencies then contains plans specific to a pandemic, natural disaster, unscheduled absence of caregiver, or other.

7) If "other, the Health plan shall describe in "Emergency_Plan_Other_Specify."

8) If the member's HAP addresses personal goals and preferences then it will be reported in "Personal_Goals."

9) If the member's HAP assesses risks and safety factors it will be reported under "Risks_Safety."

10) The Health Plan must attest if the HAP addresses all assessed risks and safety factors

11) If the member's HAP addresses services and supports need then it will reported under "Services_Supports."

12) The Health plan must attest if the HAP addresses all assessed services and supports.

13) The Health Plan will also report if the HAP had documented provision of choice of providers and services to the member.

14) The Health Plan shall record the service types approved in the HAP, if there were any service types delivered that were not in the HAP, and a description of those different types of services.

15) The Health Plan shall record the service scopes approved in the HAP, if there were any service scopes delivered different that were not in the HAP, and a description of those different scope of services.

16) The Health Plan shall record the service amounts approved in the HAP, if there were any service amounts delivered that were not in the HAP, and a description of those different service amounts.

17) The Health Plan shall record the service durations approved in the HAP, if there were any service durations delivered that were not in the HAP, and a description of those different service durations.

18) The Health Plan shall record the service frequency approved in the HAP, if there were any service frequencies delivered that were not in the HAP, and a description of those different service frequencies.

g. Financial

1) The Health Plan shall report the HCPCS/CPT code for the type of service described in the data format file.

2) The Health Plan shall classify each procedure into a service category (1 = Direct Service; 2 = Residential Care; 3 = Services; 4 = Other) based on the HCPCS/CPT code

crosswalk in the data format file. The Health Plan shall report the service category listed in the data format file.

3) The Health Plan shall report the number of service units authorized to be provided during the reporting timeframe in "Service_Units_Auth."

4) The Health Plan shall report the number of service units billed (not yet paid) with service dates during the reporting time frame in "Service_units_billed."

5) The Health Plan shall report the number of service units paid with service dates during the reporting timeframe in "Service_units_Paid."

6) The Health Plan shall report the total paid amount for service units paid with service dates during the reporting timeframe in "Total_paid_amounts."

3. In **Section II: Aggregate Data Worksheet** the Health Plan shall report on aggregate and summary data on HCBS settings implementation. Each tab corresponds to a specific category: 1) Providers, 2) Members, 3) Health Action Plans, and 4) Financial. At the bottom are auto-calculated metrics. The Health Plan shall use data reported in the Section I Member- and Provider-level Data Files to generate aggregate metrics in Section II.

a. Providers Tab

1) The first column describes the level of geography that is required for that row of data: 1) Statewide, 2) Oahu, 3) Kauai, 4) Maui, 5) Lanai, 6) Molokai, 7) Hawaii Island

2) The second column describes the type of provider that will be reported in that column: 1) ALF, 2) CCFFH, 3) E-ARCH, 4) Adult Day Care, 5) Adult Day Health, 6) Community Case Management, 7) Counseling and Training, 8) Non-

medical Transportation, 9) Personal Assistance Services, 10) Respite Care, 11) Skilled Nursing, 12) Private Duty

3) The third column corresponds to data that the Health Plan shall report for each column specification.

4) The fourth column corresponds to the total number of providers. The Health Plan shall report the total number of providers that satisfy the metric criteria.

5) The fifth column, "# of existing providers", is defined as providers who were providing services before day 1 of the reporting period and continued to provide services.

6) The sixth column, "# of new providers", is defined as new providers who began providing services during the reporting period that were never providing services prior to day 1 of the reporting period.

7) The seventh column, "# of licensed providers", is the number of providers that meet DHS license requirements.

8) The eight column, "# of unlicensed providers", is the number of providers that do not meet DHS license requirements and includes self-directed providers.

9) The ninth column, "# employees", includes the number of employees within a provider. If the provider is the only employee than the number will be equal to one.

10) Metrics, many of which are broken down by geography and provider type, include:

b. Total Providers

1) # providers in compliance with HCBS setting requirements before service delivery

2) # providers in compliance with HCBS setting requirements

3) # of provider applications received in reporting period

4) # of provider applications received and contracted in reporting period

5) # of provider applications received, contracted, and met appropriate credential requirements prior to service

6) # of providers delivering services trained on how to identify, address, and seek to prevent A/N/E/D.

7) # of providers that meet training requirements prior to providing services

8) # of employees in agencies providing services who are actively providing services

c. Members Tab. The Health Plan shall report the number of members that meet each of the specific metrics. These include:

1) # of existing members past quarter

2) # of new members enrolled in past quarter

3) # of existing members who had LOC evaluation completed

4) # of new members who had LOC evaluation completed

5) # of existing members who had LOC evaluation completed using approved form and process

6) # of new members who had LOC evaluation completed using approved form and process

7) # of existing members enrolled in previous quarter found eligible for HCBS

8) # of new members enrolled in previous quarter found eligible for HCBS

9) # of existing members enrolled in HCBS

10) Total # of existing members enrolled in HCBS

11) Total # of new members enrolled in HCBS

12) # of new members receiving HCBS services educated on how to identify, address, and seek to prevent A/N/E/D

13) # of existing members receiving HCBS services educated on how to identify, address, and seek to prevent A/N/E/D

d. Health Action Plans Tab

1) The Health Plan shall develop a methodology of probability-based sampling (not convenience sampling) that takes into account various stratum including potentially oversampling specific islands or rural communities and types of providers. The Health Plan shall use "Sampling A Practical Guide for Quality Management in Home & Community-Based Waiver Programs" that starts on page 254.

2) The Health Plan shall report the number of members that meet each of the following metrics:

3) # members receiving HCBS.

4) # of HCBS members with service plans that were included in the sample.

5) # of HCBS members with service plans reviewed (i.e. final sample).

6) # of HCBS members with health action plans that include an individualized contingency plan for emergencies

7) # of HCBS members with health action plans reviewed that address personal goals and preferences

8) # of HCBS members with health action plans reviewed that addressed assessed risks and safety factors.

9) # of HCBS members with health action plans reviewed that assessed services and support needs.

10) # of HCBS members with health action plans reviewed that were updated at least annually or was revised, as needed, to address changing needs

11) # of HCBS members with health action plans reviewed that demonstrated type of services were delivered in accordance with the service plan

12) # of HCBS members with health action plans reviewed that demonstrated scope of services were delivered in accordance with the service plan

13) # of HCBS members with health action plans reviewed that demonstrated duration of services were delivered in accordance with the service plan

14) # of HCBS members with health action plans reviewed that demonstrated amount of services were delivered in accordance with the service plan

15) # of HCBS members with health action plans reviewed that demonstrated frequency of services were delivered in accordance with the service plan

16) # of HCBS members with health action plans reviewed that demonstrated the member was offered choice among providers

17) # of HCBS members with health action plans reviewed that demonstrated the member was offered choice among services

e. Financial Tab

1) The Health Plan shall report each of the following metrics by the four service categories defined in the data format file.

2) The second column reflects the number of service units billed or paid with service dates

3) The third column represents the number of service units authorized for the reporting period

4) The fourth column represents the total the Health Plan paid with service dates.

5) The fifth column represents the total Health Plan allowed amounts.

6) The Health Plan shall describe the sampling methodology used for the Health Action Plan metrics. The Health Plan shall further report the sample frame size, target sample size, and final sample size.

204.5 Key Performance Indicators (KPIs)

a. DHS shall monitor the Health Plan's performance using the following metrics.

1) Percent of providers delivering HCBS services who are in full compliance with the HCBS Setting Requirements

2) Percent of new providers delivering HCBS services who are in full compliance with the HCBS Settings Requirements prior to service delivery

3) Percent of new non-licensed/self-directed providers that met training requirements prior to providing services to HCBS members

4) Percent of new Oahu HCBS provider applications from non-licensed/self-directed providers received during the previous quarter that met the appropriate credential requirements prior to service delivery

5) Percent of new Kauai HCBS provider applications from non-licensed/self-directed providers received during the previous quarter that met the appropriate credential requirements prior to service delivery

6) Percent of new Maui HCBS provider applications from non-licensed/self-directed providers received during the previous quarter that met the appropriate credential requirements prior to service delivery

7) Percent of new Lanai HCBS provider applications from non-licensed/self-directed providers received during the previous quarter that met the appropriate credential requirements prior to service delivery

8) Percent of new Molokai HCBS provider applications from non-licensed/self-directed providers received during the previous quarter that met the appropriate credential requirements prior to service delivery

9) Percent of new Hawaii Island HCBS provider applications from non-licensed/self-directed providers received during the previous quarter that met the appropriate credential requirements prior to service delivery

10) Percent of new members who had an approved LOC determination prior to receiving HCBS services

11) Percent of LOC evaluations completed using the approved LOC form and process

12) Percent of members whose health action plans were delivered in accordance with the service plan, including the type, amount, frequency, and duration specified in the service plan

13) Appropriate and implemented sampling methodology for health action plans reviews

14) Percent of total services units billed or paid that are supported by the appropriate documentation

REPORT 205:   SPECIAL HEALTH CARE NEEDS

205.1   Introduction

A) The purpose of this report is to track the Health Plan's provision of Special Health Care Needs (SHCN) and Expanded Health Care Needs (EHCN) services. The data gathered will be used to assess contract compliance and quality of services provided, including the extent to which members are receiving health coordination and community delegation of these services.

205.2   Applicable Contract Sections

A) Section 3.7 (Health Coordination Services) contains a description of Health Coordination Services (HCS) and the populations (i.e., SHCN, EHCN, Long Term Services and Supports, Community Integration Services) eligible for these services. Section 3.7.D contains the Health Plan's responsibilities for SHCN and EHCN populations.

B) Section 2.6 (Definitions/Acronyms) defines the SHCN and EHCN populations.

C) Section 6.2.E.2 (Reports related to Covered Benefits and Services) provides information on the SHCN 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.

7. **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 to review and update the HAP.

8. **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.

9. **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 Individualized Service Plan, and the Individualized Plan in the past.

10. **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).

B) SHCN Definitions

1. For the purpose of this report, Health Coordination Services (HCS) are categorized into six types / core areas of services.

Service	Definition	Examples (List not Exhaustive)
1 Comprehensive Care Management	Comprehensive care management means activities to conduct client outreach and engagement, comprehensive needs assessments and re-assessments, and development of a person-centered care plan that incorporates an individual's clinical and non-clinical needs in the areas of physical health, behavioral health, prescription drug, trauma-informed care needs, and social supports.	Conducting outreach and engagement activities to engage the attributed but unenrolled eligible population; Completing standardized comprehensive needs assessments and re-assessments for eligible members; Screen for social risk factors and develop mitigation strategy to address needs; Develop a comprehensive, person-centered care plan (i.e., HAP) based on the completed assessment (other members of the care team including clinicians, family or care takers and social support agencies will contribute to the care plan); Review HAP goals, objectives, and actions with the member and track progress; Identify if significant changes have

		occurred; HAPs will be comprehensively updated following comprehensive reassessments; Identify gaps in care and development mitigation strategy to address the gaps.; Medication management, including regular medication reconciliation and support of medication adherence.
2 Care Coordination	Care coordination means facilitating access to and monitoring the delivery of services identified in a participant's care plan. Care coordination includes the facilitation of interdisciplinary teams to regularly review care plans and progress toward goals. This is accomplished through face-to-face and other means contact with participants, participant's family and support persons, and with primary, behavioral health, and specialty care providers	Working with members to implement, update and maintain their care plan; Assisting members to navigate health, behavioral health, long term services & support, and social service systems; Making referrals, scheduling and accompanying members to appointments, as needed; Continuous monitoring of progress toward goals identified in the HAP through face-to-face and other contacts with members, member's family and support persons, and primary, behavioral health, and specialty care providers; Coordinate a team of decision makers to review the case including the PCP, other providers as appropriate, the member, and others; Monitoring and supporting treatment adherence (including medication management and reconciliation); Communicating and consulting with other providers and the members and member's supports; Coordinate services with Medicare FFS and/or Medicare Advantage Plans if applicable; Facilitating regularly scheduled interdisciplinary team meetings to review HAP and assess

		progress; Facilitate timely communication across the care team to avoid duplication of services and medication error, including but not limited to discharge instructions and discharge summaries from facilities; Support for collaborative care model of physical and mental health integration; Verify receipt of services; Verify satisfaction with providers and services.
3 Health Promotion	Health Promotion means 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.	Encouraging and supporting health education for the member, member's family and support persons; Assessing the member's, family and support persons' understanding of the member's health condition and motivation to engage in self-management; Teaching and promoting self-management skills, including connecting members to self-care and other programs to help enhance their understanding of their conditions and HAP; Using evidence-based practices, such as motivational interviewing, to engage and help member participate in and manage their care; Promoting wellness and prevention programs by assisting members with resources that address: exercise, nutrition, stress management, substance use reduction/ cessation, smoking cessation, self-help recovery resources, and other wellness services based on member needs and preferences; Encouraging and facilitating routine preventive care such as flu shots and cancer screenings; Monitor progress with EPSDT

		requirements; Conducting medication reviews and regimen compliance.
4 Comprehensive Transitional Care	Comprehensive Transitional Care means the facilitation of services for the member, family and support persons when the member is transitioning between levels of care (including, but not limited to emergency department, hospital inpatient facility, residential treatment facility, rehabilitation facility, nursing facility, community-based group home, family or self-care).	Establish relationships with other care settings (hospitals, residential settings, rehabilitation settings, other treatment settings, longer term services and supports providers) to promote smooth transitions between levels of care and back into the community; Manage transitions of care; Ensure prompt notification and ongoing communication of admissions/discharges from EDs, hospitals, inpatient residential, rehab or other treatment settings; Provide continuity of care when the members are discharged from a facility (e.g., resolving instances like the prescribed medication is not on the Health Plan's formulary); Active participation in discharge planning with other treatment settings to ensure consistency in meeting the goals of the member's HAP; Communicating, providing education and promoting self-management with the member, family, support persons and providers in settings where member is leaving and transitioning; Transition support to permanent housing; timely access to follow-up care post discharge that includes the following: Receipt of a summary of care record from the discharging entity, Medication reconciliation, Reevaluation of the care plan to include and provide access to needed community support services, A

		plan to ensure timely scheduled appointments).
5 Individual and Family Support	Individual and Family Support services involve activities to ensure members and member's supports are knowledgeable about information and supports needed to manage the member's condition and promote quality of life. These services including identifying supports needed for the member, family and support persons, and assisting them to access these services.	Providing education and guidance in support of self-advocacy; Provide assistance in resolving any concerns about service delivery and providers; Providing caregiver counseling or training to include skills to provide specific treatment regimens, obtain information about member's condition, and navigate service system; Assessing the strengths and needs of the members, family, and support persons; Identifying barriers to improving their adherence to treatment and medication management; Identifying resources to assist members, family, and support persons in acquiring, retaining, and improving self-help, socialization and adaptive skills; Providing information and assistance in accessing services such as: self-help services, peer support services, support groups, and respite services; Coordinating, facilitating, and arranging access to services; Accompanying member to appointments, as needed; Advocating for member, family or support person to identify and obtain needed resources that support their ability to meet their health goals; Provide support for housing transition and sustaining services to support housing providers to ensure member's ability to sustain or transition to housing; Discuss advanced directives with members, family and support persons; Assist the

		member with maintaining continuous Medicaid benefits.
6 Referral to Community / Social Support	Referral to community/social support means providing information, referrals, and assistance to members, family and support members to available community and social support services.	Identifying the member's community and social support needs; Providing referral and information assistance to members in obtaining community-based resources and social support services, including services addressing social risk factors such as housing, food security and nutrition, employment counseling, childcare, disability services, and other social services; Leverage existing community resources lists to provide comprehensive community resources guides to members; Identifying resources to reduce barriers to help members in achieving their highest level of function and independence; Actively managing and following up with referral sources, member, member's family and support members, to ensure members are engaged in services as appropriate; Coordinating appointments or other engagement with social support services and managing follow up; referral to community support to address social risk factors.

205.4   Methodology

A) This report is organized into three sections.

1. In Section 1, the Health Plan shall provide aggregate metrics on the total members by group (i.e., SHCN, EHCN) at each stage of the continuum of care (i.e. identification, screening, assessment,

development and implementation of the HAP, etc.) and HCS provided for each new SHCN Members and existing SHCN members in the Aggregate-Level Data File (ALDF)

2. In Section 2, the Health Plan shall provide member-level data on progress along the continuum of care and HCS provided in each of the six core areas of service (i.e. Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support, Referral to Community/Social Support).

3. In Section 3, the Health Plan shall provide descriptive details about SHCN/EHCN during the reporting period;

B) Data Sources:

1. The Health Plan shall report aggregate and member-level data from a number of sources. In addition to administrative records, SHCN-specific sources for metrics in the MLDF include:

   a. SHCN/EHCN Assessment

   b. SHCN/EHCN Health Action Plan

C) Data Collection/Reporting:

1. The Health Plan shall report on SHCN and EHCN services that have been implemented across the continuum of care for each new SHCN members and existing SHCN members. The report shall include all members that were active at any time during the reporting period. The report shall exclude services related to member enrollment in Long Term Services and Supports and Community Integration Services.

2. There is overlap in the six HCS core areas such that a single service could fall under multiple core areas. In reporting under each of the six core areas of HCS, each service shall only be reported one time. In the event that a service can be dually

categorized, the Health Plan shall choose whichever core area the intent of the service is closest to (e.g., medication management can fall under multiple core areas, but medication changes following a hospital discharge aligns closest with the core area Comprehensive Transitional Care).

3. **Section 1**: In the embedded Excel document, the Health Plan shall enter numerical data into all applicable cells.

   a. All data entered in the ALDF will be stratified by group (SHCN, EHCN, and Hale Ola, if applicable).

   b. All aggregate metrics shall be focused on activities conducted during the reporting quarter, unless otherwise specified. For example, "members newly enrolled in the Health Plan who completed new member welcome call/survey" shall be limited to newly enrolled members who completed the new member welcome call/survey during the reporting period.

   c. The Excel document contains two tabs, which correspond to (1) new SHCN/EHCN members who were identified as potentially eligible, determined eligible, and enrolled in SHCN services during the reporting period and, (2) existing SHCN/EHCN members, who were enrolled and receiving SHCN services prior to the start of the reporting period.

   d. Unplanned hospital admissions are defined using 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.hcup-us.ahrq.gov/tools_software.jsp

1) For tables identified in the methodology below, please refer to "Reference Tables and Data Submission Format.xlsx" in this report's subfolder within the "Report Reference Tables and Data Submission Formats" folder.

2) The planned admission algorithm follows two principles to identify planned readmissions:

    i. 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).

    ii. 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).

3) Tables B1, B2, B3 and B4 are provided in the reference tables document to support the health plan in identifying planned admissions.

4) Once planned admissions have been identified, Unplanned admissions = All Admissions - Planned Admissions

e. The Health Plan shall provide information on new SHCN/EHCN members who were enrolled in SHCN during the reporting period in the Aggregate Metrics (New SHCN) tab.

f. All metrics in the categories "Member Screening for SHCN/EHCN Eligibility" and "Eligibility Confirmation" shall be reported as totals across the SHCN population, i.e., not for SHCN and EHCN separately.

g. For all metrics in the remaining categories (i.e., Enrollment in SHCN/EHCN, Initial Assessment, Initial Health Action Plan, Health Coordination Services Received, Data Sharing, Service Delegation) the Health Plan shall report total Members for each SHCN Only, EHCN Only, and SHCN and EHCN combined.

h. Examples of data sources used in data analytics to identify existing members as potentially eligible include, but are not limited to, claims data; Admission, Discharge, Transfer (ADT) feeds; prescription refills and history; clinical information, such as blood pressure; laboratory values, such as HbA1c; and data collected on social risk factors.

i. "Members identified by any method" as potentially eligible for SHCN/EHCN include members identified via data analytics, new member survey/welcome call, quality improvement initiative, any type of referral (i.e., provider, self, or other referral), or other means.

j. Examples of follow up actions to confirm eligibility include, but are not limited to, contacting the member by phone, letter, and/or system notification.

k. For members potentially eligible who have not been reached to participate, "reached" means in person or phone contact with the member for confirmation of eligibility and participation.

l. The Health Plan shall provide information on existing SHCN/EHCN members who were enrolled and receiving SHCN services prior to the start of the reporting period in the Aggregate Metrics (Existing SHCN) tab.

m. New SHCN/EHCN members who were enrolled in SHCN services during the reporting period shall NOT be included in

this tab. The two tabs in the ALDF are designed to be mutually exclusive.

n. Number of existing SHCN/EHCN members on the first day of the reporting period is the total enrollment of SHCN/EHCN members as of the first day of the reporting period.

o. Number of existing SHCN/EHCN members on the last day of the reporting period is the total enrollment of SHCN/EHCN members on the last day of the reporting period, excluding the new SHCN/EHCN members (i.e. new SHCN/EHCN member information shall NOT be reported in this tab). This number may be lower than the number of existing SHCN/EHCN members on the first day of the reporting period if some SHCN Members stopped receiving services within the reporting period.

p. Existing SHCN/EHCN members that were due or overdue for a re-assessment on the first day of the reporting period includes members whose most recent assessment (either initial assessment or re-assessment) was completed during the same quarter or earlier of the prior year.

q. Existing SHCN/EHCN members that completed a re-assessment includes all SHCN/EHCN members who completed a re-assessment within the reporting period.

r. Existing SHCN/EHCN members that were due or overdue for a comprehensive update to their HAP on the first day of the reporting period includes members whose most recent HAP (either initial HAP or comprehensive update to the HAP) was completed during the same quarter or earlier of the prior year.

s. Existing SHCN/EHCN members that completed a comprehensive update to their HAP includes all SCHN/EHCN members who completed a comprehensive update to their HAP within the reporting period.

t. Existing SHCN/EHCN members that were due or overdue for a review of their HAP during the reporting period includes all members whose initial HAP, AND most recent comprehensive update to the HAP, AND most recent review of the HAP were all more than 90 days prior to the end of the reporting period. Members who were reported as being due for a comprehensive update to their HAP within the reporting period shall not be reported again here.

u. Existing SHCN/EHCN members whose Health Coordination Services are fully delegated/contracted to community providers includes all members who received ALL of their HCS (i.e. assessment, re-assessment, development/update/reviews of HAP, and services provided in each of the six core areas) from community providers, NOT the Health Plan.

v. Existing SHCN/EHCN members whose Health Coordination Services are partially delegated/contracted to community providers includes all members who receive SOME of their HCS (i.e. assessment, re-assessment, development/update/reviews of HAP, and services provided in each of the six core areas) from community providers, in addition to receiving some HCS from the Health Plan. Members reported under full delegation to community providers shall not be reported here.

w. The metrics category in each tab (i.e. Aggregate Metrics (New SHCN) and Aggregate Metrics (Existing SHCN)) will be populated automatically using numbers entered by the Health Plan for the previous metrics.

4. **Section 2**: The Health Plan shall submit a Member-Level Data File (MLDF) quarterly.

a. The Health Plan shall follow guidance for naming each variable and coding responses in the MLDF using the "MLDF Data Submission Format" tab in the "Reference Tables and Data Submission Format" document.

b. Data sources for the MDLF predominantly include, administrative records, assessments (reassessments), HAPs (initial, comprehensive updates, reviews).

c. Missing data: in the case of missing data in the MLDF, the Health Plan shall use the indicator "-999". If the data field is N/A, then leave the data field blank; the Health Plan shall not enter 0 for missing or N/A data.

d. The Health Plan shall report a combination of new data that (i.e. current for the reporting period) and past data (i.e. data reflected in past reports) that serves to track the Health Plan's contract compliance. All columns in the MLDF have the potential to be new/current data or past data, depending on when the member was identified, enrolled, and the timeline of when members are due for re-assessments and comprehensive updates to the HAP. Exceptions to this rule include:

1) The current HAP review date, which should always be new data because of the contractual standard that the HAP shall be reviewed at a minimum every 90 days;

2) The number of services received by the member in each of the six core areas within the reporting period, and who provided those services;

3) All of the quality of life and quality of services questions asked directly to the member once per reporting period (starting with GENERAL_HEALTH and beyond).

e. There are also instances in which the same value will be entered in multiple places for the same member. These instances include:

1) Date of second most recent assessment: this could indicate the initial assessment (in which case the same date would be entered under date of initial assessment and date of second most recent assessment) or a re-assessment.

2) Date of most recent assessment: the most recent assessment may be in the initial assessment (in which case the same date would be entered under date of initial assessment and date of most recent assessment). The most recent assessment may also be the second most recent assessment in the case that only an initial assessment and first re-assessment were completed for the member.

3) As a general rule, if a member is enrolled in SHCN for under one year, it would be expected that the same date is entered for all three assessment date fields (i.e. initial assessment, second most recent assessment, most recent assessment).

    i. As a general rule, if a member is enrolled in SHCN for under two years, it would be expected that the same

date is entered for date of second most recent assessment and date of most recent assessment.

4) Date of second most recent HAP: this could indicate the initial HAP (in which case the same date would be entered under date of initial HAP and date of second most recent HAP) or a comprehensive update to the HAP.

5) Date of most recent HAP: the most recent HAP may be the initial HAP (in which case the same date would be entered under date of initial HAP and date of most recent HAP). The most recent HAP may also be the second most recent HAP in the case that only an initial HAP and first comprehensive update to the HAP were completed for the Member.

6) As a general rule, if a member is enrolled in SHCN for under one year, it would be expected that the same date is entered for all three HAP dates fields (i.e. initial HAP, second most recent HAP, most recent HAP).

   i. As a general rule, if a member is enrolled in SHCN for under two years, it would be expected that the same date is entered for date of second most recent HAP and date of most recent HAP.

7) Date of second most recent review of HAP: the second most recent review of the HAP may be the same as the date of the most recent comprehensive update (if the comprehensive update was completed within 180 days) or the same as the date of the initial HAP (if the initial HAP was completed within 180 days).

8) Date of most recent review of HAP: the most recent review of the HAP may be the same as the date of the most

recent comprehensive update (if the comprehensive update was completed within 90 days) or the same as the date of the initial HAP (if the initial HAP was completed within 90 days).

f. Under "HOSPITALIZATION," the Health Plan shall report acute hospitalizations. Under "INSTITUTIONALIZATION," the Health Plan shall report on any stay in an institutional setting.

g. Under ID_METHOD, "Other Referral" would represent a referral from anyone else besides provider, or self, or otherwise identified through a quality improvement initiative, etc. Therefore, this might be referrals from the community, the member's family, etc. The final option, "Other Means" is a catch all for a referral that fails to fit any option above for some reason.

5. In **Section 3**: The Health Plan shall provide descriptive details about SHCN/EHCN services during the reporting period. These qualitative questions can be found in the report template document.

205.5 Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance on the Special Health Care Needs Report:

1. Data analytics to identify existing members potentially eligible for SHCN services

2. Percent of new Health Plan members with completed new member welcome call or survey to screen and identify eligibility for SHCN/EHCN

3. Percent of existing Health Plan members who were identified by data analytics as potentially eligible for SHCN/EHCN

4. Percent of Health Plan members who are potentially eligible for SHCN/EHCN but have not been reached

5. Percent of members whose initial assessment was completed within window (less than or equal to 15 days from identification via data analytics or new member welcome call/survey)

6. Percent of members whose initial Health Action Plan was completed within window (less than or equal to 30 days from when the initial assessment was completed)

7. Percent of members overdue for their re-assessment (last assessment was greater than 12 months before the last day of the reporting period)

8. Percent of members whose most recent HAP was comprehensively updated within 12 months of the last day of the reporting period

9. Percent of members enrolled in SHCN/EHCN prior to the start of the reporting period who experienced two or more unplanned hospitalizations

10. Percent of Special Health Care Needs members receiving at least one Health Coordination Service per quarter

11. Percent of Expanded Health Care Needs members receiving at least one Health Coordination Service per month

12. Percent of members whose Health Action Plans were shared with their PCPs

REPORT 206:   GOING HOME PLUS

206.1   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 quality of services provided, contract compliance, and evaluation of cost outcomes associated with engagement.

206.2   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.

206.3   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.

206.4 Methodology

A) This report is organized into two sections.

1. Section 1: An Aggregate-Level Data File (ALDF) to evaluate and monitor service provision; and

2. Section 2: Four Member Level Data Files (MLDF1, MLDF2, MLDF3, and MLDF4) to gather member-level data for evaluation and reporting purposes.

B) Data Sources:

1. The Health Plan will report aggregate and 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. 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.

3. The tab "HCBS Services Reference" provides procedure codes included as part of QI HCBS services. All other non-HCBS Services shall be considered "GHP Services."

4. Four tabs contain MLDF Data Submission Formats.

5. MLDF1 shall be used to report Member Enrollment Data. The Health Plan shall upload data on all GHP members enrolled as of, and since, January 1, 2017. Up to six enrollment segments may be reported for members who disenrolled and re-enrolled in GHP. Each GHP Member shall be listed on a single row in this dataset.

6. MLDF2 shall be used to identify encounters the Health Plan has previously submitted to HPMMIS on GHP Members.   Only CRNs associated with LTSS expenditures (i.e. nursing facility, other institutional care including waitlist, subacute services, HCBS, etc.) and GHP expenditures should be included.

7. MLDF3 shall be used to report all expenditures not reported to HPMMIS including both LTSS and GHP expenditures.

8. MLDF4 shall be used to capture improper payments on self-directed care services.

C) Data Collection/Reporting:

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

2. In **Section 1**, the ALDF will primarily use administrative and encounter data collected by the Health Plan. The Health Plan

should enter the numeric data into the "value" column next to each metric in the ALDF datasheet.

3. For the ALDF, please report only for activities conducted during the reporting quarter.

4. Metrics are based on monitoring for program activities.

5. The aggregate data file contains two tabs:

    a. GHP Enrollment and Transition; and

    b. HCBS and GHP Services - MOE

6. The GHP Enrollment and Transition section of the report will assess the Health Plan's activity related to introducing new GHP members, confirming their eligibility, enrolling members in services, transitions across settings, total LTSS costs and completion of the QoL survey. This section will also address the number of waitlisted members at various time points during the reporting period, and members transitioned off of the waitlist.

7. The HCBS and GHP Services section of the report heavily relies upon the "HCBS Services Reference" tab in the reference table document above.

    a. This section assesses HCBS and GHP services provided to GHP members, as well as costs of these services by category and replaces the previously required Maintenance of Effort (MOE) report. Health plans shall report information using paid claim dates that fall within the reporting period instead of service date.

8. Several metrics in each of the tabs listed above (GHP Enrollment and Transition; and HCBS and GHP Services) will be populated automatically using numbers entered within the report.

9. In **Section 2**, the MLDF will be used to evaluate GHP member outcomes by assessing member-level data.

10. When reporting data in the MLDF, Health Plans should follow guidance for naming each variable and coding responses using the MLDF Data Submission Format tabs in the reference table document.

11. Missing data: For the MLDF, there may be instances of missing data. In these cases, the Health Plan should use the indicator "-999". If the data field is N/A, then leave it blank. Please do not enter 0 for missing or N/A data.

12. For MLDF1, MLDF2, and MLDF3, the Health Plan shall report all data available to the Health Plan on GHP members since 1/1/2017.

206.5   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. % Members who completed GHP who have been re-institutionalized

4. % GHP Expenditures reported as encounters into HPMMIS

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 two sections:

1. Section 1: aggregate metrics

2. Section 2: member level data that correspond to the aggregate metrics collected.

B) Health Plans shall collect and maintain data on all language translations and interpretations provided, including for American Sign Language.

C) 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.

D) In **Section 1**: Aggregate Metrics the Health Plan shall complete the aggregate metrics listed.

1. For "Number of New Requests", list total number of new requests for interpretation or translation received in the quarter, by DHS Language Group. For "Number of Outstanding Requests," list total number of outstanding requests received in the prior calendar quarter(s) that the Health Plan fulfilled in the report quarter, or requests received in the prior calendar

quarter(s) that the Health Plan continued to work on fulfilling in the report quarter, even if the request was not fulfilled.

2. For "Number of Requests Fulfilled" list the total number of requests for interpretation or translation that were fulfilled in the quarter, including requests from prior calendar quarter(s) that were fulfilled in the report quarter.

3. Calculate the "Median Business Days to Fulfill Requests" among all requests that were fulfilled during the report quarter. The number of business days to fulfill requests is calculated as the interval between the date of the requested services, and the date the request was fulfilled. 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.

4. Across all requests fulfilled in the quarter, report the "Maximum Business Days to Fulfill Requests" as the number of business days the request that took the longest to fulfill.

5. Report the number of requests that were fulfilled within 5 business days under "Number Fulfilled within 5 Business Days of Request".

6. Report the number of requests that were fulfilled on the same day that they were requested under "Number Fulfilled on Date Requested". As noted earlier, 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.

7. In addition, the Health Plan shall also list any other concerns or challenges with providing interpretations and translations during the report quarter.

E) **Section 2**: Section 2 provides a member-level data file (MLDF).

1. The format of the MLDF is provided in the "Language Reference and 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 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.

4. For "Medicaid ID" list the Med-QUEST Assigned Member Identification Number

5. For "Service 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.

6. The "Type of Service Requested" shall be either an interpretation ("I") or translation ("T").

7. 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.

8. 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.

9. 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.

10. 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.

11. Use the "Language Ref" tab to map the "DHS Language Group" corresponding to the language into which translation or interpretation services were requested.

12. Notate whether service was provided using a "Y" or "N" in the "Service Provided" field.

13. List the "Service Provided Date"; if the service was not provided then leave blank

14. 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.

15. "Service Location" identifies whether the service was provided in person ("IP"), by telephone ("TP") on in writing ("WR"). In person services include face-to-face telehealth sessions.

16. 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.

17. 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. Median Business Days to Fulfill Interpretation Requests

2. Median Business Days to Fulfill Translation Requests

3. Percent of Interpretation Requests Fulfilled on Date Requested (Top 25 Languages)

4. Percent of Translation Requests Fulfilled on Date Requested (Top 25 Languages)

5. Percent of Interpretation Requests Fulfilled within Five (5) Business Days (Top 25 Languages)

6. Percent of Translation Requests Fulfilled within Five (5) Business Days (Top 25 Languages)

7. Percent of Interpretation Requests Fulfilled (All Languages)

8. Percent of Translation Requests Fulfilled (All Languages)

REPORT 302:   1179 FORM REPORTING

302.1   Introduction

A) The Health Plan shall report to DHS any changes that affect the status of Members in its Health Plan; in lieu of completing and submitting the 1179 Form.

302.2   Applicable Contract Sections

A) Section 9.2 Health Plan Enrollment Responsibilities describes the responsibilities of the Health Plan to submit changes in member status to DHS through the 1179 form.

302.3   Terms and Definitions

A) **KOLEA Case #:** The 8 digit Med-QUEST Assigned number associated with the member's KOLEA case.

B) **Case Name**: The first and last name associated with the KOLEA Case. Enter this information as [FIRST NAME] [LAST NAME].

C) **Member Medicaid ID #:** The 10 digit Med-QUEST Assigned Member Identification Number.

D) **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.

E) A) **Med-QUEST Eligibility Branch Offices**: The most up-to-date contact information for the Med-QUEST Eligibility Branch Offices may be found on the Med-QUEST website:

https://medquest.hawaii.gov/en/resources/med-quest-offices.html

302.4 Methodology

A) This report is organized into two sections.

   1. Section 1: Change of Address and Phone

   2. Section 2: Other Change Reports

B) In **Section 1: Change of Address and Phone**, the Health Plan shall provide DHS with an Excel file containing Change of Address and Phone number updates for members every month. For required data elements and formats, please refer to "1179_MLDF_DataFormat.xlsx" in this report's folder within the "Report Reference Tables and Data Submission Formats" folder.

C) In **Section 2: Other Change Reports**, the Health Plan shall provide a summary of the 1179 Health Plan Change Report Form that the Health Plan submits over the reporting month. The Health Plans shall use the 1179 Health Plan Change Report Form as linked below to report on any changes impacting Medicaid members that the Health Plan becomes aware of.

   1.

     https://medquest.hawaii.gov/content/dam/formsanddocuments/client-forms/1179-health-plan-change-report-form/DHS1179-Form-Rev1013-100713.pdf/_jcr_content?type=pdf&process=

D) For all 1179 Report submissions the Health Plan shall provide the following information:

   1. **To**: The name of the MQD Office/Eligibility Unit

   2. **From**: The name of the Health Plan submitting the 1179 form

   3. **Date**: The date of 1179 Report completion

   4. **Phone No**.: The phone number of the point of contact at the Health Plan

5. **Effective Date of Change**: The date the reported change came into effect (MM/DD/YY)

6. **Case Name**: The name of the primary contact for the member's KOLEA case

7. **Case #**: The member's KOLEA Case Number

8. **Adult Member**: The adult member on the KOLEA Case

9. **Interpreter required**:

E) For reports of a Name Change, the Health Plan shall complete the "Name Change" portion of the 1179 containing the following information:

1. **From**: the original name of the member (last, first, middle initial, and Client ID #)

2. **To**: the new name following change (last, first, middle initial)

F) For Addition to Family/Deletion from Family, the Health Plan shall complete the "Addition To Family" or "Deletion From Family" portion of the 1179 containing the following information:

1. **Name**: Name of added or deleted member

2. **Client ID#:** Member Medicaid ID # of added or deleted member

3. **Relationship to Principal Insured Party:** check value for Spouse, Son, Daughter, Stepchild, or Other

4. **Date of Birth:** member date of birth (MM/DD/YY)

5. **ADRC Requested:** if a request was made to the Aging and Disability Resource Center, the date request made (MM/DD/YY)

6. **Mother's Name:** if reporting a birth, the mother's last name, first name, and middle initial

7. **Mother's Client ID #:** if reporting a birth, the mother's Medicaid ID #

8. **Date of Death:** if reporting a death, the member's date of death (MM/DD/YY)

G) For Report of Pregnancy/Termination of Pregnancy, the Health Plan shall complete the Report of Pregnancy or Termination of Pregnancy portion of the 1179 containing the following information:

1. **Name**: name of member reporting pregnancy or termination of pregnancy, last name, first name, middle initial

2. **Client ID#**: Member Medicaid ID # of member reporting pregnancy or termination of pregnancy

3. **EDC**: estimated due date of pregnancy (MM/DD/YY)

4. **Termination Date**: date of pregnancy termination (MM/DD/YY)

H) For reports of Report or Change of Third Party Liability (TPL) Coverage, the Health Plan shall complete the "Report or Change of Third Party Liability (TPL) Coverage" portion of the 1179 containing the following information:

1. **Name**: Name of insured member

2. **Client ID#**: Member Medicaid ID # of insured member

3. **Name of TPL**: Name of the insurance plan providing third party liability coverage

4. **Type of TPL**: Medical, Drug, Dental, Vision, or Psych (circle one)

5. **Acct/Member/Policy No.**: Account, member, or policy number for insurance coverage

6. **Eff/Term Date**: Date insurance became effective or was terminated (circle one)

7. If available, the Health Plan shall include a copy of the members' insurance card when reporting this change

8. For Change of TPL Coverage, Health Plans shall send the Change Reports to the Med-QUEST Finance Office:

Mailing Address:

MQD/FO/TPL Section

1001 Kamokila Blvd. Suite 317

Kapolei, HI 96707-2005

Fax Number:

692-7989

I) For reports of Miscellaneous Changes, the Health Plan shall complete the "Miscellaneous Changes" portion of the 1179. The Health Plan shall use the line provided to record the miscellaneous change.

302.5   Report Indicators

A) Did the Health Plan populate the Email Address field for all members in the Change of Address and Phone Number report?

REPORT 303:   CALL CENTER

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:

1. In **Section I: Call Center Metrics** the Heath 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.

B) The Health Plan shall gather information from its call centers' premise-based equipment and call center sign-in information to complete this report.

C) The longest hold time and average speed of answer shall be recorded in minutes, with accuracy up to two decimal places.

D) 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.

E) 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. Average CSR Productivity: The actual number of calls handled in the quarter (i.e. Calls Successfully Delivered to a CSR) divided by the "Expected Number of Calls Handled in the Quarter" which provides actual CSR productivity as a proportion of theoretically expected CSR productivity.

7. CSR Active Time: The "Total CSR Active Call Center Response Time in Hours" divided by the "Call Center Sign in Hours" which provides the percentage of total sign-in time spent plugged in, logged in, handling calls, making outgoing calls, or in the after-call work state.

8. Percent of Callbacks Resolved in a Timely Manner: Percentage of Calls requiring Callbacks that were Resolved within Five (5) Business Days.

9. Occupancy Rate: Occupancy is the percent of time CSRs were plugged-in, logged-in, handling calls, making outgoing calls, or in the after-call work state.

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) N/A

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 "MGA_MLDF_DataFormat.xlsx" 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 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.

2. There may be instances of missing data. The Health Plan should use the indicator "-999" or variation of to fit the character length. If the data field is N/A, then leave it blank. Do not enter 0 for missing or N/A data.

C) Health Plans shall complete the ALDF for standard grievances (no extension granted) and for grievances with an approved extension. In the ALDF, a grievance may fall in one or more grievance category, service category, and population. A grievance may be counted multiple times in these categories when applicable.

D) In **Section II: Appeals** the Health Plan shall complete all fields in the embedded excel file in the report by referring to "MGA_MLDF_2_DataFormat.xlsx" 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.

2. There may be instances of missing data. The Health Plan should use the indicator "-999" or variation of to fit the character length. If the data field is N/A, then leave it blank. Do not enter 0 for missing or N/A data.

E) Health Plans shall complete the ALDF and stratify by the following three dimensions: standard appeals (no extension granted),

expedited appeals, and grievances with an approved extension. In the ALDF, an appeal may fall in one or more grievance category, service category, and population. A grievance may be counted multiple times in these categories when applicable.

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 within 5 business days: The percent of grievances with written acknowledgement sent back to the member within five business days of original receipt of grievance.

2. Percent of grievances with notice of decision within 30 days: The percent of grievances with the notice of decision sent back to the member within 30 days of the original receipt of the grievance without an approved extension.

3. Percent of appeals with written notice of acknowledgement within 5 business days: The percent of appeals with written acknowledgement sent back to the member within five business days of original receipt of the appeal.

4. Percent of appeals with notice of decision within 30 days: The percent of appeals with the notice of decision sent back to the member within 30 days of the original receipt of the grievance without an approved extension.

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.

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 Plain 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) **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.

L) **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.

M) **Claims Denial Reasons**:

1. Not Meeting PA/Referral Requirements

2. Late Submission

3. Provider Ineligible on Date of Service

4. Member Ineligible on Date of Service

5. Member TPL Was Not Billed First:

6. Additional Information Needed

7. Duplicated Claims

8. Not Member Responsibility (e.g. General Excise Tax (GET))

9. Other

N) **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 (excluding 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) and Revenue Code is NOT between 0450-0459 or 0981

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, 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 DataFormat 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 claim lines, as opposed to claims.

3. The tabulation will calculate the percentage of claims processed within 30 and 90 days of date of receipt.

4. 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.

3. The tabulation will calculate the percentage of claims processed within 30 and 90 days of date of receipt.

4. 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.

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	Bonuses for quality; penalties for lower quality or missed benchmarks

	rates on select performance measures.	
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) **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); ~~and~~

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

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

E) 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.

F) **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. If the cell is not applicable, enter N/A for text fields and 0 for numeric fields.

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 Initaitive

6) Whether the Named Initiative is a pilot or not

7) Whether the Named Initative 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.

G) **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 been 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 ~~contracted~~ 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. Arrangements without a–meaningful quality component should be listed under one or more non-VBP Categories (i.e. 1F, 3N or 4N as applicable).

8. Payments made based on Diagnostic Related Groups (DRG) shall be treated as non-VBP payments unless coupled with one or more VBP arrangements.

9. 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.

10. 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).

11. 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.

H) **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 "~~Total~~ 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.

I) **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 (a) monitor the Health Plan's compliance with the network adequacy requirements and (b) provide an in-depth quantitative and qualitative review of the provider network adequacy criteria.

403.2   Applicable Contract Sections

A) Section 8.1.B (Provider Network) describes the specific minimum requirements of the provider network.

B) Section 8.1.D (Geographic Access of Providers) describe time and distance standards for the provider network.

C) Section 8.1.I (Telehealth Services) enables the use of telehealth to enhance provider access.

D) Section 6.2.E.1. (Report Descriptions, Provider Network/Services) describes the requirements of the Provider Network Adequacy Verification Report.

403.3   Terms and Definitions

A) N/A

403.4   Methodology

A) This Report is organized into four 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 report aggregate metrics based on a detailed analysis of its provider network.

2. In Section 2, 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.

3. In Section 3, the Health Plan shall provide a Member Level Data File that contain record-level data that supported the reporting of the aggregate metrics in Section 1.

4. In Section 4, the Health Plan shall qualitatively evaluate remaining gaps in its provider network and describe its strategies to addressing or closing those gaps.

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

1. First, providers who are designated as 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."

2. The Health Plan shall identify the following providers based on information available to the Health Plan without a distinct provider type or specialty:

   a. Urgent Care Providers

   b. Peer Support Specialists

   c. Personal Emergency Response System (PERS) Providers

   d. Home Health Agencies

   e. Community Health Workers

   f. 24-Hour Pharmacies (as distinct from all other pharmacies)

g. Chore Service Providers

C) Beginning with providers of Specialized Services (Provider Type S1), the Health Plan shall identify the following sub-types:

1. Environmental Accessibility Adaptations Providers

2. Moving Assistance Providers

3. Home Maintenance Providers

4. Other Specialized Services Providers

D) Next, the Health Plan shall refer to "Reference Tables and Data Submission.xlsx" 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.

E) The mapping shall be completed in two steps:

1. First the Health Plan shall use the "PNA Provider Type Ref" table 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.

F) All Primary Care Providers, including those classified as PCPs and grouped as "Primary Care (Adult)" or "Primary Care (Child)" based on the first step, as well as other Primary Care Providers who were not classified as PCPs, shall be grouped into "Primary Care Providers."

1. By contrast, behavioral health providers who do not fit into other behavioral health categories shall be classified as "All Other Behavioral Health Providers."

G) 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.

H) The Health Plan shall use the information in the "Provider Group-PNA Category" tab to map any remaining PNA provider category to Provider Group.

I) The Health Plan shall use the tab labeled "Geographic Groupings" to parse provider practice zip codes into island, as well as "urban" versus "rural." Therefore, any given provider's practice may be grouped into a variable called Island_Rurality where a given provider's practice location may, for example, be "Oahu-Urban" or "Kauai-Rural".

J) 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 only be considered in one PNA Provider Category in a Provider Group. For example, if a provider has two specialties under the Provider Group of "Specialists" (e.g. a provider who is a cardiologist and an endocrinologist), the provider may only be listed once based either on which specialty is more prominent in the members they serve, or based on which specialty is listed as their Primary Taxonomy Code. The following exceptions are noted:

   a. Primary care providers who have been classified as PCPs under "Primary Care (Adult)" or "Primary Care (Child)" may be recounted under "Primary Care Providers."

   b. Given that Psychiatric Nurse Practitioners may be counted in lieu of Psychiatrists in Rural Areas, the PNA Provider Categories "Psychiatrists", "Nurse Practitioners (Psychiatric)" and "Psychiatrists + Nurse Practitioners (Psychiatric)" may contain duplicates.

   c. Pharmacies may also serve as 24-hour Pharmacies. In this case, the Pharmacy may be counted twice as applicable under the provider group "Other."

   d. Larger clinics, FQHCs and CHCs that serve as PCP to hundreds to thousands of Medicaid members, including both adults and children, may not serve one type of "dominant" population as noted in Section 403.4.B.1 of the current report. Therefore, these types of providers who serve as PCPs may be included in both PCP categories (PCP(Adult); and PCP(Child)).

   e. Providers of specialized services for LTSS who provide more than one type of specialized services (e.g. moving assistance

and environmental accessibility adaptations) may be counted twice in both categories.

6. 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.

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

K) 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.

L) 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 (13-44 years): Female members who are 13 years or older, and younger than 45 years.

3. Members needing/utilizing Behavioral Health services:

a. The Health Plan shall use the definitions provided in the four "Need-Use BH Services" tabs.

b. "Need-Use BH Services (1_Dx)" includes behavioral health diagnostic codes

c. "Need-Use BH Services (2_ProcCd)" includes procedure codes (CPT and HCPCS) associated with behavioral health services

d. "Need-Use BH Services (3_NDC)" includes drugs prescribed to treat behavioral health conditions.

e. "Need-Use BH Services (4_Rev Cd)" includes behavioral health revenue codes

f. 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 18 months prior to the start date of the reporting period. A member appearing on any of the four lists shall be included in this population.

4. 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.

5. Additionally, the Health Plan shall use the tab labeled "Geographic Groupings" to parse all members by residential zip codes into "urban" versus "rural."

M) 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 ASSIGNED 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.

N) Aggregate Metrics shall be reported in **Section 1**. To report aggregate metrics, the Health Plan shall complete the following steps:

1. Report data separately by rural, urban, and statewide settings as shown. Classification of data into rural vs. urban should be based on the member's classification as "rural" rather than the provider's classification as "rural." Therefore, statewide metrics for members represents a simple aggregation of members classified as either rural or urban. On the other hand, providers appearing in both urban and rural settings in a given provider category must be deduplicated while reporting statewide metrics.

2. In the column "Number of Members Served" enter the number of members in either the urban or rural settings, or statewide, based on the population served by the PNA Provider Category (All members, Adults (21 years and older), Children (0 to <21 years), Members utilizing BH services, Members Receiving HCBS (Both At Risk, and those meeting Level of Care), Members Receiving HCBS (Only those meeting Level of Care), LTSS Members in Nursing Facilities or in a Waitlist Category, or Women of reproductive age (13-44 years)).

3. In the column "Number of Contracted Providers" enter the number of providers who the Health Plan was actively contracted with on the first day of the reporting period in that PNA Provider Category.

4. "Number of Providers Meeting Contract Ratio Standard" only applies to providers subject to any contract ratios:

   a. PCP (Adult) (1:300)

   b. PCP (Child) (1:300)

   c. Psychiatrists (1:150)

   d. Psychiatrists + Nurse Practitioners (Psychiatric) (1:150 in rural areas)

   e. All Other Behavioral Health Providers (1:100)

   f. To complete this field, the Health Plan shall separately calculate the number of members attributed to or receiving service from the provider and calculate the contract ratio standard at the provider level. The Health Plan shall report the number of providers meeting or exceeding the contract standard (i.e. for PCPs, 1:300 or better ratio).

5. "Total Capacity of Contracted LTSS Facilities" only applies to residential facilities or day treatment centers for LTSS members.

Here, the Health Plan shall list the total maximum capacity of these facilities (total spots, or total beds).

6. "Number of Non-English Speaking Members" shall use information provided in the Health Plan's daily or monthly 834 file. Member language may be found in the 2100A Loop, LUI segment, LUI01 or LUI02 Language Codes, which indicate the primary language spoken in the member's household. The Health Plan shall identify all members for whom English is a second language.

7. Using it's own data, the Health Plan shall identify providers who speak languages other than English and report the number of providers who speak a non-English language by PNA Provider Category in the "Number of Non-English Speaking Providers"; the report does not require further analysis at the language-level at this time.

8. The remaining metrics shall be gleaned from the DTA.

9. The Health Plan shall create three versions of the Aggregate Metrics file.

10. "Aggregate Metrics – Physical Network" shall be based on all providers in the network, based on their physical location, and not including their capacity to provide telehealth-based services.

11. "Aggregate Metrics – Physical-Virtual Network" shall be based on all providers in the network, including both providers who are physically located in a given area, and providers who are available to members through telehealth.

12. "Aggregate Metrics – Accepting Members" shall be based only on providers who are actively accepting QUEST members (i.e. accepting new patients). These metrics shall include both physically and virtually available providers.

O) In **Section 2**, 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.

2. The Health Plan shall include all providers enrolled on the first day of the reporting period.

3. 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".

4. 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.

5. 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.

6. Telehealth practice fields including PROV_TELEHEALTH and PROV_TH_ISLAND shall be completed as applicable.

7. 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.

8. The Health Plan shall identify providers who speak fluently in languages other than English in the PROV_NON_ENG field.

P) In **Section 3**, 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_".

Q) In **Section 4**, the Health Plan shall qualitatively evaluate any gaps in its provider network and describe its strategies to addressing or closing those gaps.

403.5   Key Performance Indicators (KPIs)

A) DHS shall use the following KPIs to evaluate Health Plan performance. KPIs will be parsed by urban, rural and statewide settings.

B) KPIs based on the physical network alone:

1. Minimum required contracted Hospitals per island for all islands served

2. Percentage of PCPs (serving adults) who do not exceed the Provider-Member Ratio standards

3. Percentage of PCPs (serving children) who do not exceed the Provider-Member Ratio standards

4. Occupancy of LTSS settings nearing or exceeding capacity for any of the following settings: Adult Day Care/Adult Day Health, Assisted Living Facilities/E-ARCH, CCFFH, Nursing Facilities, or Respite Care Facilities

5. Percent of Adult Members with access to their PCP within the Driving Time Standards

6. Percent of Child Members with access to their PCP within the Driving Time Standards

7. Overall ratio of Ob/GYNs to women of reproductive age

8. Number of Provider Categories (out of 43 in Urban settings; 42 in Rural settings) with Driving Time Standards where fewer than 85% of Members needing or using those services have access to the Provider Categories within the Driving Time Standards.

C) KPIs based on the physical and virtual network combined:

1. Percentage of Psychiatrists (or Psychiatrists and Psychiatric Nurse Practitioners in rural settings) who do not exceed the Provider-Member Ratio standards

2. Percentage of All Other Behavioral Providers who do not exceed the Provider-Member Ratio Standards

3. Number of Provider Categories (out of 43 in Urban settings; 42 in Rural settings) with Driving Time Standards where fewer than 85% of Members needing or using those services have access to the Provider Categories within the Driving Time Standards.

4. Number of Provider Categories (out of 43 in Urban settings; 42 in Rural settings) with Driving Time Standards where fewer than 85% of Members needing or using those services have access to the Provider Categories within the Driving Time Standards.

D) KPIs that consider the network after it is restricted to providers with no restrictions/caps on QUEST members and who are currently accepting new QUEST members.

1. Percentage drop in overall ratio of Ob/GYNs to women of reproductive age exceeding 20%

2. Number of Behavioral Health Provider Categories (out of 6) with percentage drops in overall ratio of provider to members exceeding 20%

3. Number of Specialists Provider Categories (out of 19) with percentage drops in overall ratio of provider to members exceeding 20%

4. Number of Provider Categories (out of 43 in Urban settings; 42 in Rural settings) with Driving Time Standards where fewer than 70% of Members needing or using those services have access to the Provider Categories within the Driving Time Standards

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:

3. Any providers who have been suspended, terminated, denied credentialing or voluntarily separated from the Health Plan in the reporting period;

4. Any employees who have been suspended, terminated, denied credentialing or voluntarily separated from the Health Plan in the reporting periods;

5. 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 key 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

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 provider suspensions or terminations that were 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
6. OHANABH

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.

Use the "FQHC RHC Clinics" Excel file to map Billing Provider Name to Clinic 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.

BB) **DATE_PAID**: Date claim was adjudicated. The Health Plan shall format this date DD/MM/YYYY.

CC) **BILLED_AMOUNT**: Billed amount from detail line of claim.

DD) **CO-PAYMENT**: Amount member responsible for from the detail line of claim.

EE) **PAID_AMOUNT**: Medicaid paid amount for detail line of claim.

FF) **PRIMARY/SECONDARY**: Whether Medicaid was the Primary payer or Secondary payer for the claim. The Health Plan shall limit responses to "Primary" and "Secondary".

GG) **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.

HH) **COUNT_OF_FFS_CLAIMS/ENCOUNTERS**: The number of claims/encounters paid FFS or PPS as of the report run date.

II) **COUNT_OF_CAP_CLAIMS/ENCOUNTERS**: The number of claims/encounters covered by the capitated payment.

JJ) **FFS_PAYMENTS**: Claim service payments made to the FQHC/RHC on claims with service dates during the reporting period.

KK) **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.

LL) **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.

MM) **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.

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

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

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

QQ) **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. The summary shall contain the following data elements:

1. MCO_ID
2. MCO_NAME
3. REPORT_DATE
4. CLINIC_NAME
5. CONTRACT_STATUS
6. RPT_BEGIN_DATE
7. RPT_END_DATE
8. COUNT_OF_FFS_CLAIMS/ENCOUNTER
9. COUNT_OF_CAP_CLAIMS/ENCOUNTER
10. CAP_PAYMENT
11. ADMIN_PAYMENT
12. INCENTIVE_PAYMENT
13. PRIMARY_FFS_PAYMENTS

14. SECONDARY_FFS_PAYMENTS

15. TOTAL_HEALTH_PLAN_PAYMENTS

16. THIRD_PARTY_LIABILITY

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 <u>primary</u> or <u>secondary</u> payer for each Clinic for which the Health Plan has claims and encounters during the reporting period.

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.

G) The Health Plan Claim/Encounter Line Detail Report shall contain the following data elements:

1. MCO_ID

2. MCO_NAME

3. REPORT_DATE

4. CLINIC_NAME

5. BILLING_PROVIDER_NUMBER

6. BILLING_PROVIDER_NAME

7. RENDERING_PROVIDER_NUMBER

8. RENDERING_PROVIDER_NAME

9. CLAIM_BEGIN_DATE

10. CLAIM_END_DATE

11. MEMBER_FIRST_NAME

12. MEMBER_LAST_NAME

13. MEMBER_ID_NUMBER

14. PATIENT_ACCOUNT_NUMBER

15. CLAIM_STATUS

16. HP_CLAIM_NUMBER

17. HP_CLAIM_NUMBER_DETAIL_LINE

18. MQD_CLAIM_NUMBER

19. PLACE_OF_SERVICE_CODE

20. PROCEDURE_CODE

21. PROCEDURE_CODE_DESCRIPTION

22. DATE_PAID

23. BILLED_AMOUNT

24. CO-PAYMENT

25. THIRD_PARTY_LIABILITY

26. PAID_AMOUNT

27. PRIMARY/SECONDARY

28. PRIMARY_PAYER

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

6. Percent of PPS claims paid at the appropriate PPS rate

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 8.1.C, related to Availability of Providers

B) Section 6.2.E.c. describes the Timely Access Report

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 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 two 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.

406.5 Key Performance Indicators (KPIs)

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

1. Percent of Providers Reached Statewide, by provider type (PCP (Adult); PCP (Child); Urgent Care; Behavioral Health; Specialist): Percent of providers in the category who were reached, including calls that were answered and voicemails that were returned. [Total five (5) KPIs]

2. Of Providers Reached, % Callers Offered an Appointment Statewide, by Provider Type (PCP (Adult); PCP (Child); Urgent Care; Behavioral Health; Specialist): Among providers who were reached, percent offered any appointment. [Total five (5) KPIs]

3. Percent of Providers that met Timely Access Standards Statewide, by visit types (PCP Adult (Sick), PCP Adult (Routine), PCP Child (Sick), PCP Child (Routine), Urgent Care, Behavioral Health, Specialist) [Total seven (7) KPIs]

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:

B) Continuous National Committee for Quality Assurance (NCQA) Health Plan Accreditation; and

C) 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.

1. **Section 1**: The Heath 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 of 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.

2. **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.

B) 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: Any concerns or areas of weakness noted in the Health Plan Accreditation Survey Report or other attachments.

3. NCQA Health Insurance Plan Ratings: Most Recent Health Plan Ratings across three composite areas:

   a. Consumer Satisfaction

   b. Prevention

   c. Treatment

4. Additional NCQA or Other Distinctions, Accreditations, Certifications, or Deeming: Number and name of additional

distinctions, accreditations, certifications, or deeming held by the Health Plan.

5. Current Licensure Status: Health Plan is currently licensed by DCCA to operate as a Health Plan in the State of Hawaii.

6. Current Certificate of Good Standing: Health Plan has a current certificate of good standing from DCCA.

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 (1) 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 Ratio" shall come from the Health Plan's EPSDT Report Data

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 member's race in the monthly 834 report received by the Health Plan closest to the first day of the reporting period. For the Health Plan's convenience, data submitted via the PLD file additionally contains the same Race information, and therefore, may be used as well. 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.

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.xlxs" 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.

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. (FUA Numerator + FUH Numerator + FUM numerator) / (FUA denominator + FUH denominator + FUM denominator) * (FUA denominator + FUH denominator + FUM denominator / 3)

2. The Health Plan shall then calculate the average weighted mean percentage for each stratification where indicated in the data template.

3. An example of how the weighted mean percentage shall be calculated at the member level is provided in the "Weighted Averages Example" tab in the Reference Tables document.

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. 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 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 204) 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**: 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.

8. 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.

L) **Section 3**: Section 3 shall be completed by the Health Plan in each quarter except for the quarter when Section 1 and Section 2 are

completed. 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. 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)

5. 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)

6. 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) In **Section I, Wide Scale Adoption of Prior PIPs**, the Health Plan shall report on follow-up actions since the completion of the previous PIP cycle.

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) In **Section II, Current PIP Activities**, the Health Plan shall report on its current PIP activities.

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. In the tab titled "SDOH, Access to Care, VBP" the Health Plan may list any QAPI activities tied to its SDOH plan.

8. 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.

9. In columns A-I, the Health Plan shall describe each QAPI activity. For each activity, the Health Plan shall provide the following:

10. 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.

11. The Health Plan shall list key Health Plan Personnel leading and involved with the activity in column D. This includes name and position.

12. 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.

13. 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.

14. In column G, the Health Plan shall list any partners contributing to the activity.

15. In columns H and I the Health Plan shall report the month and year that the activity started and anticipated end date, if any.

16. 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.

17. In Columns J-N, the Health Plan shall report on the Progress of each QAPI Activity.

18. 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".

19. In Column K, the Health Plan may submit any barriers they are encountering while conducting the activity such as policy-related barriers.

20. The Health Plan shall also describe their progress on the activity during the previous quarter in column L.

21. 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.

22. 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.

23. 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.

24. 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.

25. 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.

26. 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: 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 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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.

16. 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.

17. 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.

18. 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 monitor key adverse events and level of harm members experience each quarter and 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, and CIS.

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, institutional/ 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.

B) **Adverse Events Related to Medical Care**: Four types of events are considered adverse events related to medical care, including those related to adverse drug events, treatments, healthcare acquired conditions (HCAC), and other provider preventable conditions (OPPC) including medication errors. HCAC and PPC are defined in greater detail in the Provider Preventable Conditions

Report (Report 607). An "Other" category is provided for any adverse events related to medical care that cannot be grouped into the categories above. 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.

C) **Adverse Events Related to Residential Care**: Eight types of adverse events may result while the member is in institutional or residential care, including neglect, abuse, suicide attempt, exploitation, fall/injury, elopement/missing person, restraint/seclusion, and insect infestation. 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 received while receiving surgical or other medical treatment and services. A defined list of HAIs can be found here at 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 most closely is associated with the cause of the adverse event. For example, if a medication error resulted in 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. Harm may be categorized from Category A-I based on the table below. Harms associated with any category may be reported if the Health Plan is notified of the harm. Harms associated with categories F-I are required to be reported. Events in categories E-F shall be reported as adverse events resulting in temporary patient harm, but not causing death. Examples of these types of events are provided in the table below. Events in categories G-H shall be reported as adverse events resulting in permanent patient harm, but not causing death. 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 mis
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"	
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.	Adverse event, serious harm or death
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')"	
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 two sections.

1. 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.

a. 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.

b. To properly format the data file, the Health Plan shall refer to "AER_MLDF_DataFormat.xlxs" in this report's subfolder within the "Report Reference Files and Data Submission File" folder.

c. 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.

d. The member's Medicaid ID must be reported under "HAWI_ID."

e. The Health Plan shall report whether the member is enrolled in LTSS, SHCN, GHP, 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.

f. 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, resident care, and infections.

g. The severity level of the adverse event shall be reported under "Harm_Level." The categories include "no harm", temporary harm", "permanent harm", and "death". The final harm level shall be classified.

h. The Health Plan shall report if a root cause analysis was performed "Root_Cause_Analysis" to identify any precipitating and contributing factors related to the adverse event. If so, then the Health Plan must identify the contributing factors under "Contributing_Factors."

i. If a similar adverse event occurred in the same setting within the previous 12 months up to submission of the report then the Health Plan shall report "Yes" under "Similar_AE_Setting."

j. 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."

k. The Health Plan shall describe any action steps identified as a result of the adverse events in "Action_Steps."

l. 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.

m. The Provider's Med-QUEST ID shall be reported under "MQD_Provider_ID."

n. 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."

o. If a Site Visit occurred, the Health Plan shall list the date of the site visit under "Site_Visit_Date".

p. If a Site Visit occurred, the Health Plan shall describe any recommendations or action steps that precipitated as a result of the site visit.

q. 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.

r. If yes, then the Health Plan shall describe which were implemented.

2. In **Section II: Aggregate Adverse Event Data Worksheet** 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.

a. 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:

1) Number of events identified (All events) that resulted in any harm. In other words, the Health Plan shall exclude from reporting any events in harm Category A-D, where no harm occurred.

2) Number of events that resulted in temporary or permanent harm

3) Number of events that resulted in death

4) The number of events reported by the reporting deadline specified (i.e. within 72 hours of the event)

5) Number of events where the Health Plan intervened and implemented mitigating factors to prevent the re-occurrence of a similar event.

b. The number of events that resulted in temporary harm, permanent harm, and death shall add up to the total number of events reported in Column B.

c. At the bottom of the spreadsheet the Health Plan shall provide data on the total number of members covered and the total number of covered member months during the reporting period.

d. 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.

3. 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. Number of adverse events per 100 member months (Deduplicated, LTSS-Nursing Home, LTSS-At Risk, LTSS-Sub-

Acute/Waitlist, LTSS-HCBS, SHCN, CIS, GHP, Other): The denominator shall include the cumulative number of member months covered for all members in the reporting period for each group. For example, if a member was covered for one month, then became ineligible, but then was covered an additional month, the member contributes two months to the denominator. The numerator is the total number of adverse events that occurred to covered members in the reporting period. If multiple adverse events occurred to the same member then each adverse event is counted separately in the numerator. This proportion is multiplied by 100 to get number of adverse events per 100 member months. (9 KPIs in Total)

2. 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. (9 KPIs in Total)

3. Percent of adverse events reported to the Health Plan within 72 hours (Total – Deduplicated)

4. Health Plan has an adequate system or policies and procedures to retrospectively identify adverse events experienced by members.

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 three 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.

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. 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. 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.

B) Instructions on calculating Advancing Primary Care (APC) costs:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

C) 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.

1. In **Section 1**, tab 1 (Aggregate Metrics – APC), the Health Plan shall calculate and report spend across multiple, <u>mutually exclusive definitions</u> of "Primary Care Spend."

a. 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:

1) 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.

2) 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.

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

b. Primary Care Definition 2a (Beneficiary 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:

1) 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.

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

c. 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.

1) The Health Plan shall calculate its potentially wasteful health spending for the following measures at the claim line level:

   i. APA01 - Two or more antipsychotic medications

   ii. AAP00 - Pediatric Head Computed Tomography Scans

   iii. AFP05 - Annual Resting EKGs

   iv. AAPMR05 - Opiates in acute disabling low back pain

   v. AP00 - Antibiotics for Acute Upper Respiratory and Ear Infections

2) These measures were chosen based upon their relative impact on the QUEST member population.

3) 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.

i. 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.

4) The Health Plan shall follow the methods specified by the Med-QUEST Actuary to calculate spend for the five measures selected above.

5) 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.

d. 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:

1) 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.

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

e. 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.

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

   a. 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.

   b. 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.

   c. 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."

   d. 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.

3. 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.

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

   a. 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.

   b. 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.

   c. Data should be reported at the level of each individual member of the Health Plan.

   d. The member's Medicaid ID must be reported under "HAWI ID."

   e. The "Member Attribution Begin Date" is the start date of the primary care attribution for that member with a given provider.

   f. The "Member Attribution End Date" is the end date of the primary care attribution for that member with a given provider. If the member remained attributed to the given provider on the last date of the reporting period, the Health Plan shall list the end date as 12/31/2299.

   g. 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.

h. 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.

i. 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.

j. The "Member Assignment Begin Date" is the start date of the primary care assignment for that member with a given provider.

k. The "Member Assignment End Date" is the end date of the primary care assignment for that member with a given provider. If the member remained assigned to the given provider on the last date of the reporting period, the Health Plan shall list the end date as 12/31/2299.

l. 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:

1) Any primary care providers whom the member is assigned;

2) Any primary care providers to whom the member is attributed to if the Health Plan uses an attribution method;

3) Any providers who meet the "PCPE Provider" definition; and

4) Any providers who meet the "APC Provider" definition.

m. 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.

n. 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.

o. 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.

p. 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.

q. 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.

r. 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.

s. 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.

6. PCP Enhancement Spend Ratio: The ratio of the Health Plan's total spend on the PCP Enhancement Program to the amounts loaded into the Health Plan's total capitation payment for the year.

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.F.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 four sections.

B) **Section I** covers the requirements for timely reporting of the CMS MCO Drug Utilization Review Annual Survey (CMS DUR Survey) and strives to identify Health Plan responses to specific questions from the survey for inclusion in the DHS evaluation of the Health Plan.

1. Each year, per CMS requirements, DHS staff shall distribute the latest CMS DUR Survey to the Health Plans. The actual draft of this survey is released annually by CMS, and therefore is not embedded within the report template of this report. However, adherence to the deadlines provided by DHS program staff, and comprehensive completion of the CMS DUR Survey shall be considered a required component of the Health Plan's overall DUR reporting requirements.

2. In addition, specific questions from the CMS DUR Survey shall be identified by DHS for inclusion in this report. The questions are designed to be identical to those included in the CMS DUR Survey, with the intent of effectuating more active and routine monitoring of the Health Plan's progress in selected areas. The

Health Plan's responses to questions in Section 1 shall reflect at a minimum how it responded to the same question in the CMS DUR Survey, or progress since the completion of the CMS DUR Survey.

C) **Section II** 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. The Health Plan shall also describe preventive education activities conducted during the reporting period, and attach appropriate documentation.

D) In **Section III**, 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:

      1) The definitions of CMR and TMR shall align with that provided by the Centers for Medicare & Medicaid Services (CMS).

      2) 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.

         i. 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.

      3) 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.

i. 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.

4) 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.

i. 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.

5) 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.

b. Excessive Polypharmacy:

1) 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.

2) For the purposes of this report, a unique prescription is identified by its Generic Product Identifier® (GPI) "drug base name."

3) 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.

c. Multiple Chronic Conditions:

1) 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.

2) 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

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.

3) 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.

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

d. Liver Disease and Chronic Kidney Disease:

1) 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.

2) 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.

e. Medication Adherence:

1) The Health Plan shall use it's available list of maintenance medications to identify members who required maintenance medications during the reporting period.

   i. Maintenance medications must be identified based on the GPI "drug base name" level.

ii. Maintenance medications shall not include medications used to treat pain or substance use disorders (e.g. opioids, methadone).

iii. The Health Plan shall attach its list of maintenance medications to the report.

2) 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).

i. 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.

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

1) 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.

2) The Health Plan shall identify the special population after the word "DESCRIBE" in the "Category" field, and quantify the interventions provided.

i. 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.

g. MTM/All Populations:

1) 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.

2) 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.

3) 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.

h. Opioid Monitoring:

1) 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.

2) Members shall be excluded if they are receiving palliative care or hospice services.

3) 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).

4) Opioid Naïve is defined as no indication of opioid use in the past 90 days from a prescription, self report, or a dispensing event.

i. Medication-Related Poisoning:

1) 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.

2) 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.

3. Section III 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.

E) **Section IV** collects a few additional qualitative questions on the Health Plan's DUR Program and those pertaining to the Health Plan's compliance with HRS §346-59.9.

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 conducts comprehensive reviews; sets appropriate criteria, thresholds, and follow-up actions; and conducts proactive and robust educational activities for drugs evaluated by the Health Plan's Pharmacy & Therapeutics Committee.

6. Percent of members with overlapping prescriptions for ten or more medications who received MTM or MTM-like intervention

7. Percent of members with three or more co-morbid conditions who received a MTM or MTM-like intervention

8. Percent members with liver disease who received a MTM or MTM-like intervention

9. Percent of members with chronic kidney disease who received a MTM or MTM-like intervention

10. Percent of members requiring maintenance medications who received a retrospective review to check for unfilled prescription

11. Percent of members who require maintenance medications who were identified to be non-adherent to at least one maintenance medication

12. Percent of members taking any prescriptions who received a MTM/MTM-like intervention

13. Percent of members taking any opioid medications who received more than 120 MMEs at any time

14. Percent of members with overlapping opioid/benzodiazepine, or opioid/sedative prescriptions who received concurrent drug reviews

15. Percent of members with medication-related poisoning who continued to receive medications that caused the poisoning

16. Health Plan has a variety of MTM or MTM-like interventions targeting Medicaid members, including one or more programs for special populations

17. The Health Plan takes appropriate follow-up interventional, corrective, or educational activities when safety issues are identified during DUR activities.

18. The Health Plan has a robust lock-in program, actively evaluates members for eligibility for the program, and places them in the program where appropriate.

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) N/A

603.4   Methodology

A) 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) This report is organized into two sections:

C) In **Section I: Aggregate Prior Authorizations Data** 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.

   1. The Health Plan shall use the embedded worksheet titled "Procedural Code Worksheet" to notate if the provided procedural codes in each service category require a PA. The service categories include:

      a. At-Risk Services

      b. Autism Services

      c. Diagnostic Testing

      d. Durable Medical Equipment/Medical Supplies

      e. Home and Community Based Services

      f. Home Health Services

      g. Inpatient Hospital Services

      h. Outpatient Hospital Services

      i. Physician Services

      j. Preventative Services

      k. Rehabilitation Services

      l. Transportation Services

      m. Other Services

   2. The Health Plan shall mark "Yes" next to each procedural code. For "Other Services", the Health Plan shall list any other procedural codes that do not fit into one of the 12 service categories.

      a. If there were any changes to the Health Plan's prior authorization program during the reporting period (e.g.,

removal or addition of codes), the Health Plan shall update the Procedural Code worksheet and still report on any prior authorizations for those in that reporting period. In the tab titled "changes" the Health Plan shall report on these procedural codes and notate if they were "added" or "deleted" from the Health Plan's prior authorization program.

3. The Health Plan shall report the total number of procedural codes that require PAs across all categories in the report template.

4. The Health Plan shall report key PA data in the embedded worksheet titled "Aggregate PA Worksheet." The worksheet has two tabs: 1) Pediatric (members less than 21 years of age) and 2) Adults.

   a. Health Plans shall use the age of the member as of the last day of the reporting period to determine which tab the member's data shall be inputted. Data for a member should not span across multiple tabs. For example, if a member turns 21 years halfway through a reporting period then all their data will be reported into the "Adults" tab.

5. The total number of members and corresponding member months (the cumulative number of months members were covered in the reporting period) shall be reported. These are the total number of covered members during the reporting period and not just among those with PA requests.

6. The total number of PAs will be reported by service category in the column titled "Total PAs." The row and total percentages will automatically be calculated.

7. The total number of expedited PAs will be reported by service category in the column titled "Expedited PAs." The row and total percentages will automatically be calculated.

8. The total number of approved PAs will be reported by service category in the column titled "Approved PAs." The row and total percentages will automatically be calculated.

9. The total number of approved expedited PAs will be reported by service category in the column titled "Approved Expedited PAs." The row and total percentages will automatically be calculated.

10. The total number of denied PAs will be reported by service category in the column titled "Denied PAs." The row and total percentages will automatically be calculated.

11. The total number of denied expedited PAs will be reported by service category in the column titled "Denied Expedited PAs." The row and total percentages will automatically be calculated.

12. The Health Plan shall calculate the median time in days it took for standard PAs in each service category to reach a decision. Standard PAs are the Total PAs – Expedited PAs. The Health Plan shall also calculate the overall median time for all prior authorizations using all raw prior authorization data instead of the worksheet taking the median of each individual category's median PA time.

    a. Health Plans shall calculate the median time for both standard PAs with and without an extension in each separate column.

13. The Health Plan shall calculate the median time in hours it took for expedited PAs in each service category to reach a decision. The Health Plan shall also calculate the overall median time for all prior authorizations using all raw prior authorization data

instead of the worksheet taking the median of each individual category's median PA time.

    a. Health Plans shall calculate the median time for both expedited PAs with and without an extension in each separate column.

14. The total number of standard PAs (Total PAs – expedited PAs) that required more than 14 days for a decision shall be reported in Column P.

    a. Health Plans report separately for standard PAs with and without an approved extension.

15. The total number of expedited PAs requiring more than 72 hours until decision will be reported in column R.

    a. Health Plans report separately for expedite PAs with and without an approved extension.

16. For all denied PAs, the Health Plan shall report the reason for denial in the section titled "Denied Prior Authorizations (PAs)." The categories include:

    a. 0F Not Medically Necessary

    b. 0L Exceeds Plan Maximums

    c. 0M Non-covered Service

    d. Administrative Cancellation

    e. Out of Network

    f. Member Not Enrolled in Plan

17. The Health Plan shall also provide data on the number of prior authorization decision that have been appealed including:

    a. Number Overturned

    b. Number Upheld

    c. Number In Progress

d. Number Withdrawn

18. In the event an appeal request for a PA was received after the Health Plan submitted aggregate-level data in a prior report submission, the Health Plan shall include the data only in the "Denied Prior Authorizations" table in a subsequent report. The data does not need to be repeated in the "All Prior Auhorizations (PA)" table.

19. The Health Plan shall calculate the median weekly number of PAs received from its providers over the reporting period. This is calculated by first calculating the median number of PAs requests received for each week during the reporting period and then calculating the "median of medians" across the weeks in the reporting period. Then the Health Plans shall report the range of PA requests, as well which consists of the minimum number of requests to the largest (e.g., 0–70) number of PAs received per week.

D) In **Section II: Member-level Data File**, the Health Plan shall provide information on prior authorization 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.

E) 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 14 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 exetension

5. Prior Authorization Approval Rate per 100 member months

6. Prior Authorization Denial Rate per 100 member months

7. Prior Authorization Approval Rate per 100 prior authorizations requests

8. Prior Authorization Denial Rate per 100 prior authorizations requests

9. Percent of overturned prior authorization denials

10. Health Plan does not revoke, limit, condition, or restrict coverage for authorized care provided within 45 business days from the date authorization was received for any services.

11. Health Plan publicly discloses statistics regarding prior authorization approval and denial rates available online in a readily accessible format.

12. Health Plan discloses electronically in a searchable format patient-specific prior authorization requirements for individual medical services

13. Prior authorization approval is valid for the duration of all prescribed/ordered courses of treatment

14. 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.

15. Health Plan has a robust prior authorization program that eliminates prior authorization requirements for providers.

16. Health Plan is actively collaborating with other DHS Health Plans to implement an innovative and streamlined UM/prior authorization protocol for providers.

17. Health Plan has an electronic prior authorization portal/process for all providers to identify and submit prior authorization requests

18. Health Plan has a prior authorization committee to evaluate prior authorization requirements that have resulted in streamlined and improved prior authorization procedures.

REPORT 604:   PRIOR AUTHORIZATIONS PHARMACY

604.1   Introduction

A) The purpose of the Prior Medical (PA) Authorizations 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

N/A

604.4   Methodology

A) 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) Health Plans shall not include administrative denials in the MLDF of PA denials but shall include them in the overall PA program calculations in the ALDF.

C) This report is organized into three sections:

D) In **Section I: Aggregate Prior Authorizations Data** 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 "ALDF." Data is disaggregated by formulary and non-formulary drugs. The total number of members and corresponding member months (the cumulative number of months members were covered in the reporting period) shall be reported. These are the total number of covered members during the reporting period and not just among those with PA requests.

3. The total number of PAs will be reported in the column titled "Total PAs." The total, and row and total percentages will automatically be calculated.

4. The total number of approved PAs will be reported by service category in the column titled "Approved PAs." The total, and row and total percentages will automatically be calculated.

5. The total number of denied PAs will be reported by service category in the column titled "Total Denied PAs." The total, and row and total percentages will automatically be calculated.

6. The Health Plan shall calculate the median time in hours for PA decision. The median across all service categories is NOT automatically calculated at the top and shall be calculated by the health Plan. These calculations exclude any prior authorizations for which an extension was granted.

7. The total number of PA decisions that required more than 24 hours shall be reported in "PAs requiring more than 24 hours for decision." These calculations exclude any prior authorizations for which an extension was granted.

8. The Health Plan shall report the "Number of Rejections where Member was Provided 72-hour Emergency Supply."

9. For all denied PAs, the Health Plan shall report the reason for denial in the section titled "Denied Prior Authorizations (PAs)." The categories include:

   a. 04 Authorized Quantity Exceeded

   b. 0C Authorization/Access Restrictions

   c. 0F Not Medically Necessary

   d. 0M Non-covered Service

   e. 0P Requested Information Not Received

   f. 0Q Duplicate Request

   g. 0R Service Inconsistent with Diagnosis

   h. 0T Experimental Service or Procedure

      i. 0U Additional Patient Information Required

      j. 0V Requires Medical Review

      k. 0W Disposition Pending Review

      l. 0Y Service Inconsistent with Patient's Age

      m. 0Z Service Inconsistent with

      n. 10 Product/service/procedure delivery pattern

      o. 12 Patient is restricted to specific provider

      p. 13 Service authorized for another provider

      q. 27 Member no longer enrolled in health plan

      r. 28 Step Therapy Criteria has not been met/first line therapy is not documented

      s. 00 = Other

10. The Health Plan shall also provide data on the number of prior authorization decision that have been appealed including:

      a. Number Overturned

      b. Number Upheld

      c. Number In Progress

      d. Number Withdrawn

11. The Health Plan shall calculate the median weekly number of pharmacy PA requests received over the reporting period. This is calculated by first calculating the median number of PA requests received for each week and then identifying the median across the weeks. Then the Health Plans shall report the range as well which consists of the minimum number of requests to the largest (e.g., 0–70) number of PA requests received per week.

E) In **Section II: Member-level Data File**, the Health Plan shall provide information on prior authorization denials in the report template embedded by referring to "PAP_MLDF_DataFormat.xlsx" in

this report's subfolder within the "Report Reference Tables and Data Submission Format" folder.

F) 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 standard prior authorization requests requiring greater than 24 hours for a decision

2. Median time from request to decision for prior authorization requests

3. Prior Authorization Approval Rate per 100 member months

4. Prior Authorization Denial Rate per 100 member months

5. Prior Authorization Approval Rate per 100 prior authorization requests

6. Prior Authorization Denial Rate per 100 prior authorization requests

7. Percent of Overturned prior authorization denial appeals

8. Health Plan provides accurate, patient-specific, and up-to-date formularies that include PA requirements in EHR systems for purposes that include e-prescribing

9. The Health Plan either does not have step therapy requirements, or has step therapy requirements that may be overridden

10. The Health Plan does not require 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.

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 <u>more than one-half</u> of the medical/surgical benefits in that classification subject to the financial requirement.

605.4   Methodology

A) This report is organized into three sections. Section 1 covers non-financial QTLs; Section II covers NQTLs; and 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) N/A

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) 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.

d. 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.

e. 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.

f. 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 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.hcup-us.ahrq.gov/tools_software.jsp

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

   i. 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).

   ii. 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).

   iii. Tables B1, B2, B3 and B4 are provided in the reference tables document embedded above to support the health plan in identifying planned admissions.

   iv. Unplanned Re-admissions = All Re-Admissions - 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 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/Medicare-Fee-for-Service-
Payment/HospitalAcqCond/icd10_hacs. Note that DHS MQD
excludes certain HCACs as specified in
https://medquest.hawaii.gov/content/dam/formsanddocuments/me
d-quest/hawaii-state-plan/SPA_21-0011_Public_Notice_05-21-
21_and_Attachment_4_19-A_pg_1-4_CLEAN_Redline.pdf

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

A) This report is organized into two sections.

B) 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. **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.

When referencing the current CMS list of HCACs, use hospital admission date as a reference date. For example, the FY2022 list of HCACs is applicable to hospital stays with admission dates between 10/1/21-9/30/22.

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 events that resulted in temporary harm, permanent harm, or death

2. Number of PPC associated claims the Health Plan paid during the reporting period

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