



STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

August 12, 2014

MEMORANDUM

MEMO NO.
CCS-1403

TO: Ohana Behavioral Health Organization

FROM: ^{Ust} Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

SUBJECT: ANNUAL REPORTING AND MONITORING ACTIVITIES
PERIOD: JULY 1, 2014 – JUNE 30, 2015

Annually, the Med-QUEST Division's (MQD's) Health Care Services Branch (HCSB) and the External Quality Review Organization (EQRO) assess the quality and appropriateness of behavioral health care services being provided in the Community Care Services (CCS) program. The MQD closely monitors access to those services, and evaluates the behavioral health organization's (BHO's) compliance with State and Federal Medicaid managed care requirements. When necessary, the MQD imposes corrective actions and appropriate sanctions if the BHO is not in compliance with these requirements and standards. This memorandum includes the reporting/monitoring narrative and calendar of the monitoring activities. (Including reporting requirements for the Finance Office (FO) from *July 1, 2014 and continuing through June 30, 2015*).

The EQRO, Health Services Advisory Group, Inc. (HSAG), and the MQD will be issuing separate memos with the information requirements related to the EQRO's monitoring of the BHO's compliance with the Medicaid managed care provisions of the 1997 Balanced Budget Act (BBA). The HSAG will be utilizing the compliance protocols published on June 14, 2003 by the Centers for Medicare & Medicaid Services (CMS), unless otherwise designated as National Committee for Quality Assurance (NCQA) protocols.

Clarification of the reporting/monitoring activities is as follows:

A quality improvement program is an important and necessary component of a BHO's activities to ensure that its members are provided with access to cost-effective quality care. Quality improvement programs provide the BHO with a means of ensuring the best possible behavioral health outcomes and functional health status of its members through delivery of the most appropriate level of care and treatment. Quality of care is defined as care that is accessible and efficient, provided in the appropriate setting, provided according to professionally accepted standards, and provided in a coordinated and continuous rather than episodic manner (RFP 50.410). The BHO retains ultimate responsibility for all delegated activities, and the results of these activities, where applicable, should be included in the appropriate reports.

The MQD reviews focus primarily on Quality Improvement. Generally, the BHO will have 30-calendar days from the date of receipt of a report to respond to the MQD's request for follow-up, actions, information, etc., as applicable. In instances when the BHO must respond to a finding, the MQD's expectation is that the BHO will submit a written response and clearly describe the actions taken to resolve the issue(s). If the issue(s) has/have not been fully resolved, a comprehensive corrective action plan including the timetable(s) and the identification of the individual responsible for completing the action shall be submitted to the MQD. In certain circumstances (i.e., concerns or issues that remain unresolved or repeated from previous reviews or urgent quality issues), the MQD may require a 10-calendar day corrective action plan in lieu of the 30-calendar day response time. The MQD reserves the right to extend our 30-day review period as circumstances dictate. Regarding report deadlines that end on the last day of the month, if the last day falls on a non-working day, then the report(s) is/are due the first working day after the due date.

Medical record reviews will normally require that you submit all components of requested information prior to the scheduled review. The BHO is responsible for assuring that the MQD and the EQRO have access to the medical records throughout the on-site review as well as providing a copy of the requested records for the MQD and the EQRO. The BHO is allotted 60-calendar days from the date of notification request to prepare for the medical record reviews. MQD reserves the right to request additional data, information and reports from the BHO as needed to comply with CMS requirements and for its own management purposes (RFP 50.780).

When the MQD and/or the EQRO request policies and procedures (P&P's), the most current signed copy, with the official approval date, should be submitted. Please remember that if any subsequent changes are made to P&Ps, the BHO must submit a signed and dated approved copy to the MQD within 30-calendar days of the P&P change. If the BHO has previously submitted a copy of a specific P&P to MQD and the EQRO and there have been no changes, the BHO must state so in writing and include information as to when and to whom the P&P was submitted. If there are no P&Ps for a specific area, then other written documentation such as workflow charts, organizational charts, committee reporting structure diagrams, etc., must accurately document and reflect the actions taken by the BHO. These documents must also be dated and submitted to the appropriate MQD personnel for approval.

The MQD and the EQRO staff may conduct an on-site review either independently or jointly. A follow-up on-site review may be scheduled as needed, to verify implementation or to monitor the progress of any requested corrective action plans submitted to the MQD. Additionally, review of documentation that addresses other issues or deficiencies identified may initiate an on-site visit to the BHO for verification of implementation. The MQD may inspect and audit any records of the BHO and its subcontractors or provider (RFP Section 50.610).

All information, data, reports and medical records, including behavioral health and substance abuse records, shall be provided to DHS by the specified deadlines in a format described by the MQD. Each report shall be submitted to the FTP site using the appropriate code listed in this Memo. Timeliness of reporting must be maintained. The BHO may be assessed a penalty for each late report of \$200/day until the required information, data, report and medical records are received by MQD (RFP Section 61.720).

In an effort to establish a central depository site for tracking of all health plan deliverables, we have designated key staff members to receive all required reports at cmcs@medicaid.dhs.state.hi.us. ***Electronic versions of these reports shall be submitted in the form and format approved by the MQD, and shall be submitted to the MQD via the FTP server*** with the exception of the QUEST Financial Reporting Guide which will be submitted directly to the Finance Office in hard copy format. Reports will then be distributed to the responsible MQD Branch staff for review and analysis.

Please contact Jackie Indreginal, Behavioral Health Nurse Consultant, at (808) 692-8129 should you require clarification concerning any of the reporting/monitoring activities.

Attachment: Monitoring Calendar Chart

c: Patti Bazin
Cori Woo
Priscilla Thode
Grant Shiira
Sharrie Brown
Jackie Indreginal
Bonnie Marsh (HSAG)

1179 – Summary of change of member demographics

RFP Requirements: ***RFP Section 50.730***

Report Scope: ***Monthly, reporting all activities during the report month***

Report Period(s): ***Twelve (12) one-month periods starting July of this year and ending with June of next year***

Report Due Date(s): ***The 15th of each month***

Report Formats: ***Electronic file in a format described by MQD***

Code: ***1179_(YYMM) Ex: 1179_1407***

Required Report Information:

Reports shall be submitted using the format provided by the DHS.

Behavioral Health Services Report

RFP Requirements: ***RFP Section 50.750.2***

Report Scope: ***Quarterly, reporting all activities during the report quarter***

Report Period(s): ***Four (4) three-month periods, from July through September 2014, October through December 2014, January through March 2015, April through June 2015***

Report Due Date(s): ***Last day of the month following the report period end***

Report Formats: ***Electronic file in a format described by MQD***

Code: ***BHS_1409, BHS_1412, BHS_1503, BHS_1506***

Required Report Information:

Reports shall include information on services provided by acuity of member as defined in Section 40.220, sentinel incident reporting related to SPMI diagnosis, follow-up within seven (7) days after discharge from acute psychiatric admission, and any other quality measure that the DHS deems necessary.

Reports shall be submitted using the format provided by the DHS.

CCS Financial Reporting Guide Report

<i>RFP Requirements:</i>	<i>RFP Section 50.760.4</i>
<i>Report Scope:</i>	<i>Annually, reporting all activities during the report year</i> <i>Quarterly, reporting all activities during the report quarter</i>
<i>Report Period(s):</i>	<i>One (1) twelve month period, from January through December (calendar) or July through June (fiscal)</i> <i>Four (4) three-month periods, from July through September 2014, October through December 2014, January through March 2015 & April through June 2015</i>
<i>Report Due Date(s):</i>	<i>Annually, April 30th if using Calendar Year or October 31st if using State Fiscal Year</i> <i>Quarterly, Forty-five (45) days after period end</i>
<i>Report Formats:</i>	<i>Electronic file in a format described by MQD</i> <i>Hard copy submitted directly to the Med-QUEST Finance Office</i>

Please refer to the QUEST Financial Reporting Guide located in the Documentation Library at <http://www.medquest.us/RFP%20Documentation/RFPDocumentation.html> for the format and explanation of these reports.

Code: ***(Annual) AFRG_14***
FRG_1409, FRG_1412, FRG_1503, FRG_1506

Required Report Information:

The BHO shall submit financial information on a regular basis in accordance with the BHO Financial Reporting Guide provided by DHS. The financial information shall be analyzed and compared to industry standards and DHS-established standards to ensure BHO's financial solvency. DHS may also monitor financial solvency of the BHO with onsite inspections and audits.

- Financial reports must adequately reflect all direct and indirect expenditures and management and fiscal practices related to the BHO's performance of services under this contract.

Disclosure of Information on Annual Business Transactions Report

<i>RFP Requirements:</i>	<i>RFP Section 50.730</i>
<i>Report Scope:</i>	<i>At a minimum, annually</i>
<i>Report Period(s):</i>	<i>Upon contract extension or renewal; Annually (if no contract extension or renewal); and Within thirty-five (35) days after any change in ownership of the health plan.</i>
<i>Report Due Date(s):</i>	<i>Annually, October 31, 2014</i>
<i>Report Formats:</i>	<i>Electronic file in a format described by the MQD</i>
<i>Code:</i>	<i>ABT_1406</i>

Required Report Information:

Report must disclose information on the following types of transactions:

- Any sale, exchange, or lease of any property between the health plan and a party in interest (as defined in Section 1318(b) of the Public Health Service Act);
- Any lending of money or other extension of credit between the health plan and a party in interest; and
- Any furnishing for consideration of goods, services (including management services) or facilities between the health plan and the party in interest (does not include salaries paid to employees for services provided in the normal course of their employment).

Health plan shall include the following information in the transactions listed above:

- Name of the party in interest for each transaction;
- Description of each transaction and the quantity or units involved;
- Accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

The health plan shall provide the information listed below to DHS in a format determined by the DHS:

- (1)(i) The name and address of any person (individual or corporation) with an ownership or controlling interest in the health plan. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address(es).
 - (ii) Date of birth and Social Security Number (in the case of an individual).
 - (iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the health plan or in any subcontractor in which the health plan has a 5 percent or more interest.
- (2) Whether the person with an ownership or control interest in the health plan is related to another person with ownership or control interest in the health plan as a spouse, parent, child, or sibling; or whether the person with an ownership or control interest in any subcontractor in which the health plan has a 5 percent or more interest is related to another person with ownership or control interest in the health plan as a spouse, parent, child, or sibling.
- (3) The name of any other disclosing entity, as defined in 42 CFR Section 455.101 (or fiscal agent or managed care entity) in which an owner of the provider has an ownership or control interest.
- (4) The name, address, date of birth, and Social Security Number of any managing employee of the health plan.

The health plan shall submit this information at the following times:

- Upon contract extension or renewal;
- Annually (if no contract extension or renewal); and
- Within thirty-five (35) days after any change in ownership of the health plan.

Encounter Data Reporting (BHO Certification)

<i>RFP Requirements:</i>	<i>RFP Section 50.770</i>
<i>Report Scope:</i>	<i>Monthly, reporting all claim activities during the report month</i>
<i>Report Period(s):</i>	<i>N/A</i>
<i>Report Due Date(s):</i>	<i>The first and/or third Wednesday of each month</i>
<i>Report Formats:</i>	<i>Based on Health Plan Encounter Manual</i>

The BHO is required to submit encounters to the MQD at least once per month. The BHO has the option to submit encounters twice a month. Encounters must be submitted following the guidelines in the Health Plan Encounter Manual. Each encounter submission must be certified and submitted by the BHO as required in 42 CFR §438.606 and as specified in Section 50.770.

Reporting Timelines/Sanctions

- *BHO will be notified within 30 days of submission or completion of accuracy edits;*
- *If failed, BHO shall be granted a 30-day error resolution period; and*
- *If at the end of 30 days, the BHO accuracy and completion edits failure exceeds 15%, a penalty up to 10% of the monthly capitation shall be assessed.*

**Federally Qualified Health Centers/Rural Health Centers (FOHC/RHC) Services
Rendered Report**

RFP Requirements: ***RFP Section 50.730***

Report Scope: ***Annually, reporting all activities during the report year***
Quarterly, reporting all activities during the report quarter

Report Period(s): ***One (1) twelve month period, from January 1 through
December 31***
***Four (4) three-month periods, from July through September,
October through December, January through March & April
through June***

Report Due Date(s): ***May 31st following the report period end (Annual)***
The last day of the first month following the report period end

Report Formats: ***Electronic file in a format described by the MQD***

Code: ***FQH_14 (Annual report)***
FQH_1409, FQH_1412, FQH_1503, FQH_1506

Required Report Information:

Refer to the attachment file: "DHS QUEST Financial Summary File for FQHC and RHC."

Fraud and Abuse Summary Report

<i>RFP Requirements:</i>	<i>RFP Section 50.760.3</i>
<i>Report Scope:</i>	<i>Quarterly, reporting all activities during the report quarter</i>
<i>Report Period(s):</i>	<i>Four (4) three-month periods, from July through September 2014, October through December 2014, January through March 2015 and April through June 2015</i>
<i>Report Due Date(s):</i>	<i>Last day of the first month following the end of the reporting period</i>
<i>Report Formats:</i>	<i>Electronic file in a format described by MQD</i>
<i>Code:</i>	<i>FAS_1409, FAS_1412, FAS_1503, FAS_1506</i>

The BHO shall submit *Fraud and Abuse Summary Reports* that include, at a minimum, the following information on all alleged fraud and abuse cases:

- A summary of all fraud and abuse referrals made to the State during the quarter, including the total number, the administrative disposition of the case, any disciplinary action imposed both before the filing of the referral and after, the approximate dollars involved for each incident and the total approximate dollars involved for the quarter;
- A summary of the fraud and abuse detection and investigative activities undertaken during the quarter, including but not limited to the training provided, provider monitoring and profiling activities, review of providers' provision of services (under-utilization and over-utilization of services), verification with members that services were delivered, and suspected fraud and abuse cases that were ultimately not fraud or abuse and steps taken to remedy the situation; and
- Trending and analysis as it applies to: utilization management, claims management, post-processing review of claims, and provider profiling.

Reports shall be submitted using the format provided by the DHS.

GeoAccess Report

<i>RFP Requirements:</i>	<i>RFP Section 50.740.2</i>
<i>Report Scope:</i>	<i>Quarterly, reporting all activities during the report quarter</i>
<i>Report Period(s):</i>	<i>Four (4) three-month periods, from July through September 2014, October through December 2014, January through March 2015 and April through June 2015</i>
<i>Report Due Date(s):</i>	<i>Last day of the first month following the end of the reporting period</i>
<i>Report Formats:</i>	<i>Electronic file in a format described by MQD</i>
<i>Code:</i>	<i>GEO_1409, GEO_1412, GEO_1503, GEO_1506</i>

The BHO shall submit reports using GeoAccess or similar software that allow DHS to analyze, at a minimum, the following:

- The number of providers by specialty and by location with a comparison to the zip codes of members;
- Indication as to whether the provider has a limit on the number of BHO members he/she will accept;
- Indication as to whether the provider is accepting new patients; and
- Non-English language spoken (if applicable).

The BHO shall assure that the providers listed on the GeoAccess reports are the same providers that are described in the Provider Network Adequacy and Capacity Report.

In addition to the due date as identified in Section 50.730, these reports shall be submitted to the DHS at the following times:

- Upon the DHS request;
- Upon enrollment of a new population in the BHO;
- Upon changes in services, benefits, geographic service area or payments; and

- Any time there has been a significant change in the BHO's operations that would affect adequate provider capacity and services. A significant change is defined as any of the following:
 - A loss of providers in a specific specialty where another provider in that specialty is not available on the island; or
 - A loss of a hospital.

Reports shall be submitted using the format provided by the DHS.

Member Grievances & Appeals Reports

<i>RFP Requirements:</i>	<i>RFP Section 50.750.1</i>
<i>Report Scope:</i>	<i>Quarterly, reporting all activities during the report quarter</i>
<i>Report Period(s):</i>	<i>Four (4) three-month periods, from July through September 2014, October through December 2014, January through March 2015 and April through June 2015</i>
<i>Report Due Date(s):</i>	<i>The last day of the first month following the report period end</i>
<i>Report Formats:</i>	<i>Electronic file in an Excel file and spreadsheet format</i>
<i>Code:</i>	<i>MGA_1409, MGA_1412, MGA_1503, MGA_1506</i>

Required Report Information:

The BHO shall submit *Member Grievance and Appeals Reports*. These reports shall be submitted in the format provided by the DHS. At a minimum, the reports shall include:

- The number of grievances and appeals by type;
- Type of assistance provided;
- Administrative disposition of the case;
- Overturn rates;
- Percentage of grievances and appeals that did not meet timeliness requirements;
- Ratio of grievances and appeals per 100 members; and
- Listing of unresolved appeals originally filed in previous quarters.

Reports shall be submitted using the format provided by the DHS.

Prior Authorization Requests that have been Denied or Deferred Report (Behavioral Health and Pharmacy)

<i>RFP Requirements:</i>	<i>RFP Section 50.760.2</i>
<i>Report Scope:</i>	<i>Semi-annually, reporting all activities during the report period</i>
<i>Report Period(s):</i>	<i>Four (4) three-month periods, from July through September 2014, October through December 2014, January through March 2015 and April through June 2015</i>
<i>Report Due Date(s):</i>	<i>Last day of the first month following the end of the reporting period</i>
<i>Report Formats:</i>	<i>Electronic file in a format described by MQD</i>
<i>Code:</i>	<i>PAR_1412(B), PAR_1412 (P), PAR_1506(B), PAR_1506 (P)</i>

The BHO is required to correctly interpret the CCS program's benefits and appropriately apply the program's medical necessity criteria to all services requested. Report pharmaceutical and behavioral health denials/deferrals separate using format provided by DHS.

Required Report Information in section III:

- Date of the request;
- Name of the requesting provider;
- Member's name and ID number;
- Date of Birth;
- Diagnoses and service/medication being requested;
- Justification given by the provider for the member's need of the service/medication;
- Justification of the BHO's denial or the reason(s) for deferral of the request; and
- Date and method of notification of the provider and the member of the BHO's determination.

Reports shall be submitted using the format provided by the DHS. Ensure that all data is captured in the embedded files prior to submitting the report and do not merge cells in the Excel file.

Provider Complaints & Claims Report

<i>RFP Requirements:</i>	<i>RFP Section 50.740.4</i>
<i>Report Scope:</i>	<i>Quarterly, reporting all activities during the report quarter</i>
<i>Report Period(s):</i>	<i>Four (4) three-month periods, from July through September 2014, October through December 2014, January through March 2015 and April through June 2015</i>
<i>Report Due Date(s):</i>	<i>Last day of the first month following the end of the reporting period</i>
<i>Report Formats:</i>	<i>Electronic file in a format described by the MQD</i>
<i>Code:</i>	<i>PCR_1409, PCR_1412, PCR_1503, PCR_1506</i>

Required Report Information:

The following is guidance on assembling the quarterly log of provider complaints/claims report:

- The total number of resolved complaints by category (benefits and limits; eligibility and enrollment; member issues; BHO issues);
- The total number of unresolved complaints by category (benefits and limits; eligibility and enrollment; member issues; BHO issues) and the reason code explaining the status (i.e., complaint is expected to be resolved by the reporting date and complaint is unlikely to be resolved by the reporting date);
- Status of provider complaints that had been reported as unresolved in previous report(s);
- Status of delays in claims payment, denials of claims payment, and claims not paid correctly which includes the following:
 - The number of new claims submitted for processing for each month in the reporting quarter;
 - The number of claims processed from the previous month;
 - The number of claims processed for each month in the reporting quarter;
 - The number of claims to be processed each month in the reporting quarter;
 - The number of claims paid for each month in the reporting quarter,

- The number of claims denied each month in the reporting quarter;
- The percentage of claims processed (at 30 and 90 days) after date of receipt for each month of the reporting quarter;
- The number of claims denied for each month in the reporting quarter; and
- The percentage of claims denied for each of the following reasons: (1) prior authorization/referral requirements were not met for each month in the reporting quarter; (2) late submissions; (3) provider ineligible on date of service; (4) member ineligible on date of service; (5) member TPL was not billed first; (6) duplicated claims; (7) not member responsibility s.a. GET; and (8) other reasons.

Reports shall be submitted using the format provided by the DHS.

Provider Employee Fraud and Abuse Report (Provider Suspensions & Terminations)

<i>RFP Requirements:</i>	<i>RFP Section 50.740.3</i>
<i>Report Scope:</i>	<i>Quarterly, reporting all activities during the report quarter</i>
<i>Report Period(s):</i>	<i>Four (4) three-month periods, from July through September 2014, October through December 2014, January through March 2015 and April through June 2015</i>
<i>Report Due Date(s):</i>	<i>The last day of the first month following the report period end</i>
<i>Report Formats:</i>	<i>Electronic file in a format described by MQD</i>
<i>Code:</i>	<i>PEF_1409, PEF_1412, PEF_1503, PEF_1506</i>

Required Report Information:

Please include:

- All providers (physicians, non-physicians, facilities, agencies, suppliers, etc.);
- Each provider's specialty;
- Their primary city and island of service;
- Reason(s) for the action taken; and,
- The effective date of the suspension or termination.

If the BHO has not suspended or terminated any provider during these respective periods, please report this in writing. This report should also indicate if the BHO reported a suspended and/or termination to the National Practitioner Databank.

The BHO shall notify the MQD within three (3) business days of any provider suspensions and terminations, both voluntary and involuntary because of suspected or confirmed fraud or abuse. The immediate notification shall include provider's name, provider's specialty, reason for the action and the effective date of the suspension or termination.

Reports shall be submitted using the format provided by the DHS.

Provider Network Adequacy and Capacity Report

<i>RFP Requirements:</i>	<i>RFP Section 50.740.1</i>
<i>Report Scope:</i>	<i>Quarterly, reporting status at the end of the report quarter</i>
<i>Report Period(s):</i>	<i>Four (4) three-month periods, from July through September 2014, October through December 2014, January through March 2015 and April through June 2015</i>
<i>Report Due Date(s):</i>	<i>Last day of the first month following the end of the reporting period</i>
<i>Report Formats:</i>	<i>Electronic file in a format described by MQD</i>
<i>Code:</i>	<i>PNA_1409, PNA_1412, PNA_1503, PNA_1506</i>

The Behavioral Health Organization must offer an appropriate range of behavioral health services that are adequate for an anticipated number of members for the service and that the network of providers is sufficient to meet the needs of the anticipated number of members in the service area.

Required Report Information:

- Listing of all providers, including specialty or type of practice;
- Provider's location;
- Mailing address including zip code;
- Telephone number;
- Professional license number and expiration date;
- Whether provider limits number of program patients he/she will accept;
- Whether provider is accepting new patients;
- Non-English languages spoken (if applicable);
- Verification of valid license for in-state and out-of-state providers; and
- Verification that provider or affiliated provider is not on federal or state exclusions list.

The BHO shall provide a narrative that describes the BHO's strategy to maintain and develop their provider network to include but not limited to:

- Take into account the numbers of network providers who are not accepting new patients;
- Consider the geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities;
- Current network gaps and the methodology used to identify them;
- Immediate short-term interventions when a gap occurs including expedited or temporary credentialing; and
- Interventions to fill network gaps and barriers to those interventions.

Reports shall be submitted using the format provided by the DHS.

Quality Improvement Program (QIP) Report

<i>RFP Requirements:</i>	<i>RFP Section 50.760.1</i>
<i>Report Scope:</i>	<i>Annually</i>
<i>Report Period(s):</i>	<i>One (1) twelve month period, from July 2013 through June 2014</i>
<i>Report Due Date(s):</i>	<i>September 30, 2014</i>
<i>Report Formats:</i>	<i>Electronic file appropriately named; hard copy with appropriate tabs</i>
<i>Code:</i>	<i>QIP_14</i>

Required Report Information:

The BHO shall provide an annual *QIP Program Report*. The BHO's medical director shall review these reports prior to submittal to the DHS. The *QIP Program Report* shall include the following:

- Any changes to the QIP Program;
- A detailed set of QIP Program goals and objectives that are developed annually and includes timetables for implementation and accomplishments;
- A copy of the BHO's organizational chart including vacancies of required staff, changes in scope of responsibilities, changes in delegated activities and additions or deletions of positions;
- A current list of the required staff as detailed in Section 50.400 including name, title, location, phone number and fax number;
- An executive summary outlining the changes from the prior QIP;
- A copy of the current approved QIP Program description, the QIP Program work plan and, if issued as a separate document, the BHO's current utilization management program description with signatures and dates;

- A copy of the previous year's QIP Program, if applicable, and utilization management program evaluation reports; and
- Written notification of any delegation of QIP Program activities to contractors.

Reports shall be submitted using the format provided by the DHS.

**OHANA CCS PROGRAM
MONITORING CALENDAR REPORT DUE DATES
ACTIVITY IN JULY 2014 – JUNE 2015**

July 2014	August 2014	September 2014	October 2014	November 2014	December 2014	January 2015
1179 - Change Report Report Period: June 2014 Due Date: July 15, 2014	1179 - Change Report Report Period: July 2014 Due Date: Aug. 15, 2014	1179 - Change Report Report Period: August 2014 Due Date: Sep. 15, 2014	1179 - Change Report Report Period: September 2014 Due Date: Oct. 15, 2014	1179 - Change Report Report Period: October 2014 Due Date: Nov. 15, 2014	1179 - Change Report Report Period: November 2014 Due Date: Dec. 15, 2014	1179 - Change Report Report Period: December 2014 Due Date: Jan. 15, 2015
Behavioral Health Services Report Report Period: Apr 2014 – Jun 2014	CCS Financial Reporting Guide (Quarterly) Report Period: April 2014 – June 2014 Due Date: Aug. 15, 2014	Encounter Data Reporting Report Period: August 2014 Due: 1st and/or 3rd Wed.	Behavioral Health Services Report Report Period: Jul 2014 – Sep 2014	CCS Financial Reporting Guide (Quarterly) Report Period: July 2014 – Sep 2014 Due Date: Nov. 15, 2014	Encounter Data Reporting Report Period: November 2014 Due: 1st and/or 3rd Wed.	Behavioral Health Services Report Report Period: Oct 2014 – Dec 2014
Encounter Data Reporting Report Period: June 2014 Due: 1st and/or 3rd Wed.	Encounter Data Reporting Report Period: July 2014 Due: 1st and/or 3rd Wed.	QIP Program Description Report Period: July 2013 – June 2014 Due Date: Sept. 30, 2015	CCS Annual Financial Reporting (if Fiscal Year) Report Period: July 2013 – June 2014	Encounter Data Reporting Report Period: October 2014 Due: 1st and/or 3rd Wed.		Encounter Data Reporting Report Period: December 2014 Due: 1st and/or 3rd Wed.
FQHC/RHC Services Rendered Report Period: April 2014 – June 2014			Disclosure of Info on Annual Business Transactions Report Period: July 2013 – June 2014			FQHC/RHC Services Rendered Report Period: Oct 2014 – Dec 2014
Fraud and Abuse Summary Report Report Period: April 2014 – June 2014			Encounter Data Reporting Report Period: September 2014 Due: 1st and/or 3rd Wed.			Fraud and Abuse Summary Report Report Period: Oct 2014 – Dec 2014
GeoAccess Report Report Period: April 2014 – June 2014			FQHC/RHC Services Rendered Report Period: Jul 2014 – Sep 2014			GeoAccess Report Report Period: Oct 2014 – Dec 2014
Member Grievances & Appeals Report Period: April 2014 – June 2014			Fraud and Abuse Summary Report Report Period: Jul 2014 – Sep 2014			Member Grievances & Appeals Report Period: Oct 2014 – Dec 2014
Prior Auth. Denial or Deferral (BH) Report Period: April 2014 – Jun 2014			GeoAccess Report Report Period: Jul 2014 – Sep 2014			Prior Auth. Denial or Deferral (BH) Report Period: Oct 2014 – Dec 2014
...continue from			...continue from			...continue from

July 2014			Oct. 2014			Jan. 2015
<p><i>Prior Auth. Denial or Deferral (Pharm)</i> Report Period: April 2014 – Jun 2014</p>			<p><i>Member Grievances & Appeals</i> Report Period: Jul 2014 – Sep 2014</p>			<p><i>Prior Auth. Denial or Deferral (Pharm)</i> Report Period: Oct 2014 – Dec 2014</p>
<p><i>Provider Complaints & Claims</i> Report Period: Apr 2014 – Jun 2014</p>			<p><i>Prior Auth. Denial or Deferral (BH)</i> Report Period: July 2014 – Sept 2014</p>			<p><i>Provider Complaints & Claims</i> Report Period: Oct 2014 – Dec 2014</p>
<p><i>Provider Employee Fraud and Abuse (PST)</i> Report Period: Apr 2014 – Jun 2014</p>			<p><i>Prior Auth. Denial or Deferral (Pharm)</i> Report Period: July 2014 – Sept 2014</p>			<p><i>Provider Employee Fraud and Abuse (PST)</i> Report Period: Oct 2014 – Dec 2014</p>
<p><i>Provider Network Adequacy and Capacity</i> Report Period: Apr 2014 – Jun 2014</p>			<p><i>Provider Complaints & Claims</i> Report Period: Jul 2014 – Sep 2014</p>			<p><i>Provider Network Adequacy and Capacity</i> Report Period: Oct 2014 – Dec 2014</p>
			<p><i>Provider Employee Fraud and Abuse (PST)</i> Report Period: Jul 2014 – Sep 2014</p>			
			<p><i>Provider Network Adequacy and Capacity</i> Report Period: Jul 2014 – Sep 2014</p>			

Unless otherwise noted, reports are due at the end of the month in which it is listed.

**OHANA CCS PROGRAM
MONITORING CALENDAR REPORT DUE DATES
ACTIVITY IN JULY 2014 – JUNE 2015**

February 2015	March 2015	April 2015	May 2015	June 2015	July 2015	August 2015
<p><i>1179 - Change Report</i> Report Period: January 2015 Due Date: Feb. 15, 2015</p>	<p><i>1179 - Change Report</i> Report Period: February 2015 Due Date: Mar. 15, 2015</p>	<p><i>1179 - Change Report</i> Report Period: March 2015 Due Date: Apr. 15, 2015</p>	<p><i>1179 - Change Report</i> Report Period: April 2015 Due Date: May 15, 2015</p>	<p><i>1179 - Change Report</i> Report Period: May 2015 Due Date: Jun. 15, 2015</p>	<p><i>1179 - Change Report</i> Report Period: June 2015 Due Date: Jul. 15, 2015</p>	<p><i>1179 - Change Report</i> Report Period: July 2015 Due Date: Aug. 15, 2015</p>
<p><i>CCS Financial Reporting Guide (Quarterly)</i> Report Period: Oct 2014 – Dec 2014 Due Date: Feb. 15, 2015</p>	<p><i>Encounter Data Reporting</i> Report Period: February 2015 Due: 1st and/or 3rd Wed.</p>	<p><i>Behavioral Health Services Report</i> Report Period: Jan 2015 – Mar 2015</p> <p><i>CCS Annual Financial Reporting (if Calendar Year)</i> Report Period: Jan 2014 – Dec 2014</p> <p><i>Encounter Data Reporting</i> Report Period: March 2015 Due: 1st and/or 3rd Wed.</p> <p><i>FQHC/RHC Services Rendered</i> Report Period: Jan 2015 – Mar 2015</p> <p><i>Fraud and Abuse Summary Report</i> Report Period: Jan 2015 – Mar 2015</p> <p><i>GeoAccess Report</i> Report Period: Jan 2015 – Mar 2015</p> <p><i>Member Grievances & Appeals</i> Report Period: Jan 2015 – Mar 2015</p>	<p><i>CCS Financial Reporting Guide (Quarterly)</i> Report Period: Jan 2015 – Mar 2015 Due Date: May 15, 2015</p> <p><i>Encounter Data Reporting</i> Report Period: April 2015 Due: 1st and/or 3rd Wed.</p> <p><i>FQHC/RHC Services Rendered (Annual)</i> Report Period: Jan. 2014 – Dec 2014</p>	<p><i>Encounter Data Reporting</i> Report Period: May 2015 Due: 1st and/or 3rd Wed.</p>	<p><i>Behavioral Health Services Report</i> Report Period: Apr 2015 – Jun 2015</p> <p><i>Encounter Data Reporting</i> Report Period: June 2015 Due: 1st and/or 3rd Wed.</p> <p><i>FQHC/RHC Services Rendered</i> Report Period: Apr 2015 – Jun 2015</p> <p><i>Fraud and Abuse Summary Report</i> Report Period: Apr 2015 – Jun 2015</p> <p><i>GeoAccess Report</i> Report Period: Apr 2015 – Jun 2015</p> <p><i>Member Grievances & Appeals</i> Report Period: Apr 2015 – Jun 2015</p> <p><i>Prior Auth. Denial or Deferral (BH)</i> Report Period: Apr 2015 – Jun 2015</p>	<p><i>CCS Financial Reporting Guide (Quarterly)</i> Report Period: Apr 2015 – Jun 2015 Due Date: Aug. 15, 2015</p> <p><i>Encounter Data Reporting</i> Report Period: July 2015 Due: 1st and/or 3rd Wed.</p>

		<p><i>...continue from April 2015</i></p> <p><i>Prior Auth. Denial or Deferral (BH)</i> Report Period: Jan 2015 – Mar 2015</p> <p><i>Prior Auth. Denial or Deferral (Pharm)</i> Report Period: Jan 2015 – Mar 2015</p> <p><i>Provider Complaints & Claims</i> Report Period: Jan 2015 – Mar 2015</p> <p><i>Provider Employee Fraud and Abuse (PST)</i> Report Period: Jan 2015 – Mar 2015</p> <p><i>Provider Network Adequacy and Capacity</i> Report Period: Jan 2015 – Mar 2015</p>			<p><i>...continue from July 2014</i></p> <p><i>Prior Auth. Denial or Deferral (Pharm)</i> Report Period: Apr 2015 – Jun 2015</p> <p><i>Provider Complaints & Claims</i> Report Period: Apr 2015 – Jun 2015</p> <p><i>Provider Employee Fraud and Abuse (PST)</i> Report Period: Apr 2015 – Jun 2015</p> <p><i>Provider Network Adequacy and Capacity</i> Report Period: Apr 2015 – Jun 2015</p>	
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Unless otherwise noted, reports are due at the end of the month in which it is listed.

<u>HCSB Monitoring Activities</u> that need to be scheduled and may not require additional reporting by the health plans	
<ul style="list-style-type: none"> • Monitoring claims payment timeliness & payment review policies • Compliance with required language in agreements with subcontractors • Monitoring the plan's contracted provider network 	<ul style="list-style-type: none"> • Monitoring of timeliness & accuracy of encounter data submissions • Compliance with HIPAA regulations