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

December 11, 2018

MEMORANDUM

MEMO NO.
CCS-1804

TO: 'Ohana Behavioral Health Organization

FROM: /s/ Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: ANNUAL REPORTING AND MONITORING ACTIVITIES
PERIOD: JANUARY 1, 2019 – DECEMBER 31, 2019

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. 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, 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 *January 1, 2019 and continuing through December 31, 2019*).

The EQRO, Health Services Advisory Group, Inc. (HSAG), and 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 protocol Version 2.0, September 2012 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.

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 MQD's request for follow-up, actions, information, etc., as applicable. In instances when the BHO must respond to a finding, 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 MQD. In certain circumstances (i.e., concerns or issues that remain unresolved or repeated from previous reviews or urgent quality issues), MQD may require a 10-calendar day corrective action plan in lieu of the 30-calendar day response time. 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 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 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 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 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.

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 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. 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 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 mqdcmcs@dhs.hawaii.gov. ***Electronic versions of these reports shall be submitted in the form and format approved by MQD, and shall be submitted to MQD via the FTP server*** with the exception of the BHO Financial Reporting Guide which will be submitted directly to the Finance Office. Reports will then be distributed to the responsible MQD Branch staff for review and analysis.

Please contact Kris Tsuda, Behavioral Health Nurse Consultant, at (808) 692-8154 should you require clarification concerning any of the reporting/monitoring activities.

c: Tom Miller (HSAG)

Attachments:
CCS 2019 Calendar
Disclosure Attachment
QI Certification and Disclosure Forms
QI Financial Reporting Forms
QI Financial Reporting Guide
QI FQHC MCO Quarterly_Annual Reporting Requirements
PA Requests Denied-Deferred - Medical (PAB) - (rev 11.18)
Provider Network Adequacy and GeoAccess Report (PNA) - (rev 11.18)
Service Level Frequency Report (SLF) - (rev 11.18)
Suspected Fraud and Abuse Report (SFA) - (rev 11.18)

**1179 – Summary of Change of Member Demographics**

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|---|---|
| ***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 January and ending December of the report year*** |
| ***Report Due Date(s):*** | ***The 15th of each month*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***1179_(YYMM)***<br>***Example: 1179_1901, 1179_1902, 1179_1903, etc.*** |

*Required Report Information:*

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

**Behavioral Health Services Report**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 50.730 and 50.750.2*** |
| ***Report Scope:*** | ***Quarterly, reporting all activities during the report quarter*** |
| ***Report Period(s):*** | ***Four (4) three-month periods, from January through March, April through June, July through Septemberand October through December*** |
| ***Report Due Date(s):*** | ***Forty-five (45) days after period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***BHS_1903, BHS_1906, BHS_1909, BHS_1912*** |

*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 (BHO Financial Reporting Guide)**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 50.730 and 50.760.4*** |
| ***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 through December*** |
| | ***Four (4) three-month periods, from January through March, April through June, July through September and October through December*** |
| ***Report Due Date(s):*** | ***Annually, April 30th*** |
| | ***Quarterly, Forty-five (45) days after period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***CFGA_19 (Annual Report)*** |
| | ***CFG_1903, CFG_1906, CFG_1909, CFG_1912*** |

*Required Report Information:*

Refer to attachments: **QI Financial Reporting Guide**, **QI FinancialReporting Forms** and **QI Certification and Disclosure Forms**

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**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 50.730 and 60.600*** |
| ***Report Scope:*** | ***At a minimum, annually*** |
| ***Report Period(s):*** | ***Upon contract extension or renewal;<br>Annually (if no contract extension or renewal); and<br>within thirty-five (35) days after any change in ownership of the health plan.*** |
| ***Report Due Date(s):*** | ***Annually, October 31*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***ABT_19 (Annual Report)<br>ABT_date (Contract extension renewal date or 30-day report)*** |

*Required Report Information:*

Refer to attachment: **Disclosure Attachment**

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)**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 50.770*** |
| ***Report Scope:*** | ***Monthly, reporting all claim activities during the report month*** |
| ***Report Period(s):*** | ***Twelve (12) one-month periods starting January and ending December of the report year*** |
| ***Report Due Date(s):*** | ***The first and/or third Wednesday of each month*** |
| ***Report Formats:*** | ***Based on Health Plan Encounter Manual*** |

The BHO is required to submit encounters to 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.*

**FQHC or RHC Services Rendered Report (Quarterly/Annually)**

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|---|---|
| ***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 through December*** |
| | ***Four (4) three-month periods, from January through March, April through June, July through September and October through December*** |
| ***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 MQD*** |
| ***Code:*** | ***FQHA_19 (Annual Report)*** |
| | ***FQH_1903, FQH_1906, FQH_1909, FQH_1912*** |

*Required Report Information:*

Refer to the attachment file: **QI FQHC MCO Quarterly_Annual Reporting Requirements**

**Fraud and Abuse Summary Report**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 50.730 and 50.760.3*** |
| ***Report Scope:*** | ***Quarterly, reporting all activities during the report quarter*** |
| ***Report Period(s):*** | ***Four (4) three-month periods, from January through March, April through June, July through September and October through December*** |
| ***Report Due Date(s):*** | ***The last day of the first month following the reporting period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***FAS_1903, FAS_1906, FAS_1909, FAS_1912*** |

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.

**Member Grievances & Appeals Reports (Member Complaints, Grievances and Appeals)**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 50.730 and 50.750.1*** |
| ***Report Scope:*** | ***Quarterly, reporting all activities during the report quarter*** |
| ***Report Period(s):*** | ***Four (4) three-month periods, from January through March, April through June, July through September and October through December*** |
| ***Report Due Date(s):*** | ***The last day of the first month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in an Excel file and spreadsheet format*** |
| ***Code:*** | ***MGA_1903, MGA_1906, MGA_1909, MGA_1912*** |

*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.

**Overpayments Report**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 40.335.1*** |
| ***Report Scope:*** | ***Annual*** |
| ***Report Period(s):*** | ***Twelve (12) one-month periods starting January and ending in December of the report year*** |
| ***Report Dues Date(s):*** | ***The last day of the 2nd month following the report period end*** |
| ***Report Formats:*** | ***Electronic file from the health plan*** |
| ***Code:*** | ***OPR_19 (Annual Report)*** |

*Required Report Information:*

The BHO is required to recover and report all overpayments. "Overpayment" as used in this section is defined in 42 CFR 438.2. All overpayments identified by the BHO shall be reported to DHS. The overpayment shall be reported in the reporting period in which the overpayment is identified. It is understood the BHO may not be able to complete recovery of overpayment until after the reporting period. The BHO must report to DHS the full overpayment identified. The BHO may negotiate and retain a lesser repayment amount with the provider, however, the full overpayment amount will be used when setting capitation rates for the BHO. The BHO shall also maintain documentation of the education and training provided in addition to reporting the recovered amounts.

This report is an annual report which will document all overpayments, and all recovered and pending recovery amounts. Additionally, this report will specify/distinguish those overpayments which were identified as fraud, waste, and abuse, from all the rest of the overpayments included in the report. The BHO will check the reporting of overpayment recoveries for accuracy and will provide an accuracy report to the DHS upon request. The BHO will certify that the report contains all overpayments and those overpayments are reflected in either the claims data submitted in the report, or listed as an itemized recovery.

**Prior Authorization RequestDenied/Deferred Report (Behavioral Health and Pharmacy)**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 50.730 and 50.760.2*** |
| ***Report Scope:*** | ***Quarterly, reporting all activities during the report quarter*** |
| ***Report Period(s):*** | ***Four (4) three-month periods, from January through March, April through June, July through September and October through December*** |
| ***Report Due Date(s):*** | ***The last day of the first month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***PAB_1903, PAB_1906, PAB_1909, PAB_1912***<br>***PAP_1903, PAP_1906, PAP_1909, PAP_1912*** |

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 Grievance and Claims Report (Provider Complaints & Claims Report)**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 50.730 and 50.740.4*** |
| ***Report Scope:*** | ***Quarterly, reporting all activities during the report quarter*** |
| ***Report Period(s):*** | ***Four (4) three-month periods, from January through March, April through June, July through September and October through December*** |
| ***Report Due Date(s):*** | ***The last day of the first month following the reporting period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***PGC_1903, PGC_1906, PGC_1909, PGC_1912*** |

*Required Report Information:*

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

- The total number of resolved grievances by category (benefits and limits; eligibility and enrollment; member issues; health plan issues);
- The total number of unresolved grievances by category (benefits and limits; eligibility and enrollment; member issues; health plan issues) and the reason code explaining the status (i.e., grievance is expected to be resolved by the reporting date and grievance is unlikely to be resolved by the reporting date);
- Status of provider grievances 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 claims processed for each month in the reporting quarter;
    - The number of claims paid for 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 ineligibility on date of service; (4) member ineligibility on date of service; and (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 Network Adequacy and GeoAccess Report**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 50.730, 50.740.1 and 50.740.2*** |
| ***Report Scope:*** | ***Quarterly, reporting status at the end of the report quarter*** |
| ***Report Period(s):*** | ***Four (4) three-month periods, from January through March, April through June, July through September and October through December*** |
| ***Report Due Date(s):*** | ***The last day of the first month following the reporting period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***PNA_1903, PNA_1906, PNA_1909, PNA_1912*** |

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 QUEST Integration 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.

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

*Required Report Information:*

- 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.

**Provider Suspensions & Terminations Report (three business days and quarterly), Employee Suspension and Termination Report, and Provider Education and Training Report**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 50.730 and 50.740.3*** |
| ***Report Scope:*** | ***Quarterly, reporting all activities during the report quarter*** |
| ***Report Period(s):*** | ***Four (4) three-month periods, from January through March, April through June, July through September and October through December*** |
| ***Report Due Date(s):*** | ***The last day of the first month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***PIE_1903, PIE_1906, PIE_1909, PIE_1912*** |

*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 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.

The health plan shall also report if a subcontractor or employee resigns, is suspended, terminated or voluntarily withdraws from participation as a result of suspected or confirmed fraud and abuse.

These reports shall be submitted in the Provider/ Employee Integrity and Education Report (PIE) to be provided by DHS.

**Public Summary Report (PSR)**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.510*** |
| ***Report Scope:*** | ***Annually, reporting all activities during the report year*** |
| | ***Bi-annually, reporting all activities during the report period*** |
| ***Report Period(s):*** | ***One (1) twelve-month period, from January through December*** |
| | ***Two (2) six-month periods, from January through June and July through December*** |
| ***Report Due Date(s):*** | ***Annually, February 15*** |
| | ***Bi-annually, forty-five (45) days after period end*** |
| ***Report Formats:*** | ***Electronic copy in a format described by MQD*** |
| ***Code:*** | ***PSRA_19 (Annual Report)*** |
| | ***PSR_1906, PSR_1912*** |

*Required Report Information:*

The health plan shall submit quarterly metrics identified as the Public Summary Report (PSR). Information on the PSR includes but is not limited to:

- Behavioral Health

The health plan shall utilize a format provided by the DHS. The PSR shall be posted on MQD website. (Note: OHANA may show this data the QI report.)

**Quality Assurance and Performance Improvement (QAPI) Report**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 50.730 and 50.760.1*** |
| ***Report Scope:*** | ***Annually*** |
| ***Report Period(s):*** | ***One (1) twelve month period, from January through December*** |
| ***Report Due Date(s):*** | ***June 15*** |
| ***Report Formats:*** | ***Electronic file appropriately named; hard copy with appropriate tabs*** |
| ***Code:*** | ***QAP_19*** |

*Required Report Information:*

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

- Any changes to the *QAPI* Program;
- A detailed set of *QAPI* 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 *QAPI*;
- A copy of the current approved *QAPI* Program description, the *QAPI* 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 *QAPI* Program, if applicable, and utilization management program evaluation reports; and

- Written notification of any delegation of *QAPI* Program activities to contractors.

Reports shall be submitted using the format provided by the DHS or the External Review Quality Organization (EQRO).

**Service Level Frequency Report**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 50.850.4*** |
| ***Report Scope:*** | ***Quarterly, reporting all activities during the report quarter*** |
| ***Report Period(s):*** | ***Four (4) three-month periods, from January through March, April through June, July through Septemberand October through December*** |
| ***Report Due Date(s):*** | ***The last day of the first month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***SLF_1903, SLF_1906, SLF_1909, SLF_1912*** |

*Required Report Information:*

Report shall include a current list of all CCS members by service level as defined in Section 40.220. Include all encounter dates of case manager face-to-face contact, by month, based on service level. For all unmet case manager encounters, provide a detailed explanation in the space provided. If there is no comment to report, please type N/A.

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

**Suspected Fraud and Abuse Report**

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|---|---|
| ***RFP Requirements:*** | ***RFP Section 40.370.1*** |
| ***Report Scope:*** | ***Report suspected fraud or abuse*** |
| ***Report Period(s):*** | ***When a credible Allegation of fraud determined*** |
| ***Report Due Date(s):*** | ***15 calendar days of completing a preliminary investigation*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***SFA_MMDDYY*** |

*Required Report Information:*

If the health plan becomes aware of suspected fraud or abuse from any source or identifies any questionable practices, it shall conduct a preliminary investigation. If the findings of the preliminary investigation determines there is a credible allegation of fraud, the health plan must report to the DHS within 15 days of completing the preliminary investigation. A credible allegation of fraud and/or abuse is defined as an allegation that has indicia of reliability that comes from any source and has been verified. Fraud is not determined by either the DHS or the health plan. Based on all the evidence gathered, the DHS or the health plan only determines that there is the potential that an identified activity could be fraudulent.

At a minimum, this form shall require the following information for each case:

- Subject (Name and ID number);
- Source of complaint;
- Type of provider;
- Health plan contact;
- Contact information for health plan staff with practical knowledge of the workings of the relevant programs;
- Date reported to state;
- Description of suspected intention misconduct, with specific details;

- Amount paid to the provider during the past 3 years or during the period of the alleged misconduct, whichever is greater;
- Sample/exposed dollar amount when available;
- Legal and administrative disposition of the case; and
- All communications between the health plan and the provider concerning the conduct at issue.

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

**Third Party Liability (TPL) Cost Avoidance Report**

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|---|---|
| ***RFP Requirements:*** | ***Section 50.730*** |
| ***Report Scope:*** | ***Monthly, reporting all activities during the report month*** |
| ***Report Period(s):*** | ***Twelve (12) one-month periods starting January and ending December of the report year*** |
| ***Report Due Date(s):*** | ***The 15th of the first month following the report period end*** |
| ***Report Formats:*** | ***Electronic copy in a format described by MQD*** |
| ***Code:*** | ***TPL_1901, TPL_1902, TPL_1903, etc.*** |

*Required Report Information:*

The health plan shall submit *Third Party Liability (TPL)* Cost Avoidance Reports, using the format received by the DHS, which identifies all cost-avoided claims for members with third party coverage from private insurance carriers and other responsible third parties. These reports shall include any member that has a TPL that is not identified on the 834 file received by the health plan. In addition, on a quarterly basis, the health plan shall notify MQD of all of its CCS members who have commercial insurance with the same or other health plan.

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