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August 18, 2015

MEMORANDUM

MEMO NO.
QI-1513

TO: QUEST Integration (QI) Health Plans

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

SUBJECT: QUEST INTEGRATION (QI) TRANSITION OF CARE (TOC) FILES

The purpose of this memorandum is to provide guidelines and procedures to ensure that the transition of QI members from one health plan to another health plan due to the annual plan change, does not result in decreased quality of care for our beneficiaries. We wanted to ensure that you are a) reminded of the Transition of Care requirements, and b) were aware of the Transition of Care files that we will need from you, and will transmit to you as either the "sending" or "receiving" health plan and the timeframes for doing so. This is a critical time when it is essential that we ensure the smooth transition from one health plan to another, especially given many of your relatively new experience serving this population for these services.

General Transition of Care Requirements

As described in Section 41.700 of QUEST Integration RFP-MQD-2014-005, all members transferring to a new health plan on January 1, 2016 who were receiving medically necessary covered services (see below for prenatal services) the day before enrollment into their new health plan, shall continue to receive these services from their new health plan without any form of prior approval and without regard to whether such services are being provided by contracted or non-contracted providers. Health plans shall ensure that during transition of care, their new members:

- Receive all medically necessary emergency services;
- Receive all prior authorized long-term services and supports (LTSS), including both Home and Community Based Services (HCBS) and institutional services;
- Adhere to a member's prescribed prior authorization for medically necessary services, including prescription drugs, or other courses of treatment; and
- Provide for the cost of care associated with a member transitioning to or from an institutional facility in accordance with the requirements prescribed in QI RFP Section 50.210.

The health plan shall provide continuation of services for individuals with special health care needs (SHCN) and LTSS for at least ninety (90) days or until the member has received a health and functional assessment (HFA) by their service coordinator. The health plan shall provide continuation of other services for all other members for at least forty-five (45) days or until the member's medical needs have been assessed or reassessed by their Primary Care Physician (PCP) under the new plan. The health plan shall reimburse PCP services that the member may access during the forty-five (45) days prior to transition to their new PCP, as necessary, even if the former PCP is not in the network of the new health plan.

In the event the member entering the new health plan is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal services the day before enrollment, the health plan shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract) through the postpartum period.

Transition of Care Files

The Med-QUEST Division (MQD), Health Care Services Branch (HCSB) will be the Transition of Care (TOC) data intermediary, between the QI plans generating and receiving the TOC information. The initial enrollment choices are effective January 1, 2016.

MQD will receive and provide five different categories of files from/to the QI health plans:

- Member Demographics (Attachment 1)
- Paid Medical Claims (Attachment 2)
- Paid Pharmacy Claims (Attachment 3)

- Medical Referrals (Attachment 4)
- Prior Authorizations (Attachment 5)

These files will be exchanged between the MQD and the health plans on the SFTP under each health plans' respective "other/HP Reports/" folder.

Transition of Care File Timeline

Date	***Process***
October 16, 2015	QI annual plan change ends.
Week of November 2, 2015	Files describing members coming and leaving are sent to QI health plans using MQD proprietary format.
November 20, 2015	QI health plans return to HCSB files containing TOC I data (Attachment 1 – 5).
Week of November 30, 2015	HCSB to deliver TOC I data to receiving QI health plans.
January 4, 2016	QI health plans return to HCSB files containing TOC II data (Attachment 5 and open hospitalizations as of 12/31/2015).
Week of January 11, 2016	HCSB to deliver TOC II data to receiving QI health plans.

If you have questions or concerns about this process, please contact Jon Fujii at 692-8093 or email jfujii@medicaid.dhs.state.hi.us. If you have questions about the annual plan change, please contact me at 692-8050 or email at jmohrpeterson@medicaid.dhs.state.hi.us or Patti Bazin at 692-8083 or email pbazin@medicaid.dhs.state.hi.us.

Attachments

ATTACHMENT 1

Member Demographics

#	Field Name	Type	Description
1	Medicaid Client ID	text	As Assigned by DHS
2	Member Last Name	text	
3	Member First Name	text	
4	Member Middle Initial	text	If available
5	Member DOB	date	
6	Member Gender	text	
7	PCP NPI	text	
8	PCP Last Name	text	
9	PCP First Name	text	
10	PCP Middle Initial	text	If available
11	PCP Specialty	text	
12	PCP Address 1	text	
13	PCP Address 2	text	
14	PCP City	text	
15	PCP State	text	
16	PCP Zip Code	text	
17	Medicare/TPL	Y/N	Yes/No
18	HIC/Medicare ID	text	
19	Receiving LTSS?	Y/N	Yes/No
20	Cost share?	Y/N	Yes/No
21	At risk member?	Y/N	Yes/No
22	Self-direct?	Y/N	Yes/No
23	Special Health Care Needs?	Y/N	Yes/No
24	If Y to 19, 21, 22, or 23.		Attach most recent HFA and Service Plan using naming convention: MedicaidID_LastName_FirstInitial_HFA.pdf MedicaidID_LastName_FirstInitial_SP.pdf
25	History of Transplant?	Y/N	Known by QI health plan, Yes/No

Specific Guidelines

(a.) Time frame: The latest file available.

(b.) Send file as an Excel worksheet, version 2013 or lower.

ATTACHMENT 2

Paid Medical Claims

#	Field Name	Type	Description
1	HAWI Client ID	text	As Assigned by DHS
2	Claim ID	text	Health plan's claim ID
3	Detail Claim ID	text	Health plan's detail claim ID
4	Form Type	text	Either HCFA or UB
5	Service Provider NPI	text	
6	Service Provider Last Name	text	If facility include name here
7	Service Provider First Name	text	
8	Service Provider Middle Initial	text	If available
9	Service Provider Address 1	text	
10	Service Provider Address 2	text	
11	Service Provider City	text	
12	Service Provider State	text	
13	Service Provider Zip Code	text	
14	Service from date	date	
15	Service to date	date	
16	Paid date	date	
17	Primary diagnosis	text	no decimal
18	Diagnosis 2	text	no decimal
19	Diagnosis 3	text	no decimal
20	Diagnosis 4	text	no decimal
21	Total $ Charged	num	two decimal places
22	Type of bill	text	UB claims only
23	Place of service	text	HCFA claims only
24	CPT/HCPCS	text	
25	Modifer	text	First modifier
26	Quantity	num	no comma, no decimal
27	Revenue code	text	UB claims only

Specific Guidelines

(a.) The file will repeat records as many times as the claim has detail claim lines.
(e.g. One claim with 5 detail claim lines = 5 records)

(b.) This file will contain only paid medical claims; no denied claims.

(c.) Time frame: Service dates from May 1, 2015 to October 31, 2015.

(d) Lines 17 to 20, claims October 1 to October 31, 2015 dates of service should be ICD-10.

(e.) Send latest version of a claim.

(f.) Send file as an Excel worksheet, version 2013 or lower.

ATTACHMENT 3

Paid Pharmacy Claims

#	Field Name	Type	Description
1	HAWI Client ID	text	As Assigned by DHS
2	Claim ID	text	Health plan's claim ID
3	Prescriber Provider ID	text	NPI
4	Prescriber Provider Last Name	text	If facility include name here
5	Prescriber Provider First Name	text	
6	Prescriber Provider Middle Initial	text	If available
7	Pharmacy Provider ID	text	NPI
8	Pharmacy Provider Name	text	If facility include name here
9	Dispense Date	date	
10	Total $ Submitted Cost	num	two decimal places
11	Total $ Allowed Cost	num	two decimal places
12	NDC	text	No dashes
13	Drug Name	text	
14	Quantity	num	no comma, no decimal

Specific Guidelines

(a.) The file will repeat records as many times as the claim has detail claim lines. (e.g. One claim with 5 detail claim lines = 5 records)

(b.) This file will contain only paid medical claims; no denied claims.

(c.) Time frame: Service dates from May 1, 2015 to October 31, 2015.

(d.) Send latest version of a claim.

(e.) Send file as an Excel worksheet, version 2013 or lower.

ATTACHMENT 4

Medical Referrals

#	Field Name	Type	Description
	Referral		
1	Medicaid Client ID	text	As Assigned by DHS
2	Referring From Provider ID	text	NPI
3	Referring From Provider Last Name	text	If facility include name here
4	Referring From Provider First Name	text	
5	Referring From Provider Middle Initial	text	If available
6	Referring To Provider ID	text	NPI
7	Referring Provider To Last Name	text	If facility or agency include name here
8	Referring Provider To First Name	text	
9	Referring Provider To Middle Initial	text	If available

Specific Guidelines

(a.) The file will repeat records as many times as the client has Referrals
(e.g. One client with 100 referrals = 100 records)

(b.) Time frame: Referrals open as of October 31, 2015.

(c.) Send file as an Excel worksheet, version 2013 or lower.

ATTACHMENT 5

Prior Authorizations

#	Field Name	Type	Description
	Prior Authorization		
1	Medicaid Client ID	text	As Assigned by DHS
2	Primary diagnosis	text	no decimal
3	Start Date	date	
4	End Date	date	
5	Service Provider ID	text	NPI (preferred) or HI Medicaid Provider ID. If self-directed provider, include SD in this field.
6	Service Provider Last Name or Agency	text	If facility include name here
7	Service Provider First Name	text	
8	Service Provider Middle Initial	text	If available
9	Service Provider Address 1	text	
10	Service Provider Address 2	text	
12	Service Provider City	text	
13	Service Provider State	text	
14	Service Provider Zip Code	text	
15	CPT/HCPCS	text	If applicable
16	Allowed Units	num	no comma, no decimal
17	Used Units	num	no comma, no decimal
19	NDC	text	No dashes
20	Drug name	text	If applicable
21	Days Supply	num	If applicable
22	Quantity	num	If applicable. No commas, no decimals.
23	Acute Hospitalization	Y/N	Yes/No
24	If Yes, Hospital Name	text	Facility name
25	Date of admission	date	
26	Anticipated date of discharge, if unknown, leave blank	date	

Specific Guidelines

(a.) The file will repeat records as many times as the member has a Prior Authorization (e.g. One client with 100 PAs = 100 records)

(b.) Time frame TOC I: Prior Authorizations open as of October 31, 2015.

(c.) Time frame TOC II: Prior Authorizations from November 1 to December 31, 2015.

(d.) Send file as an Excel worksheet, version 2013 or lower.