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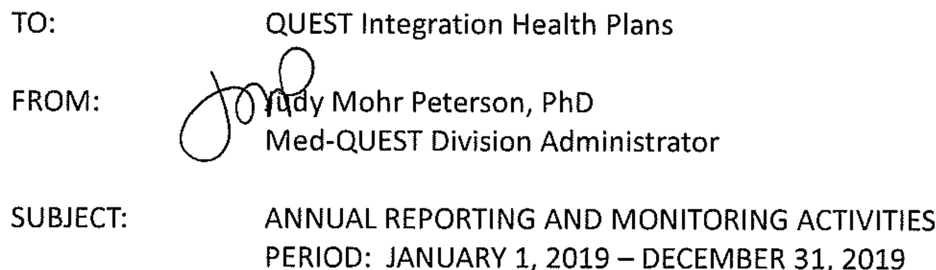
December 18, 2018

MEMORANDUM

MEMO NO.
QI-1826



TO: QUEST Integration Health Plans

FROM: 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 health care services. The MQD closely monitors access to those services, and evaluates the managed care organization's (MCO's) compliance with State and Federal Medicaid managed care requirements. When necessary, the MQD imposes corrective actions and appropriate sanctions if the MCOs are 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 the MQD will be issuing separate memos to the plans with the information requirements related to the EQRO's monitoring of the health plans' compliance with the Medicaid managed care provisions of the 1997 Balanced Budget Act (BBA). HSAG will be utilizing the compliance protocols Version 2.0, September 2012 by the Centers for Medicare and 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 assurance program is an important and necessary component of a health plan's activities to ensure that its members are provided with access to cost-effective quality care.

Quality assurance programs provide the health plans with a means of ensuring the best possible 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 Section 50.720). The QUEST Integration health plans retain 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, QUEST Integration health plans 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 health plans must respond to a finding, the MQD's expectation is that the plans 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 the 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) are due the first working day after the due date.

Medical record reviews will normally require that the plans submit all components of requested information prior to the scheduled review. The health plan 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 plans are 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 health plan as needed to comply with CMS requirements and for its own management purposes (RFP Section 51.630).

When the MQD and/or the EQRO request policies and procedures (P & Ps), 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 plans must submit a signed and dated approved copy to the MQD within 30-calendar days of the P & P change. If the plan has previously submitted a copy of a specific P & P to MQD and the EQRO and there have been no changes, the plan 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 MCO. 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 MCO for verification of implementation. The MQD may inspect and audit any records of the health plan and its subcontractors or providers (RFP Section 71.800).

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. Extension requests must be requested via email to the CMCS e-mail address (listed below) by the health plans two business days before the due date of the report. The extension must be approved by MQD before the report due date. The health plan may be assessed a penalty for late reports of $200/day until the required information, data, reports and medical records are received by MQD (RFP Section 72.220).

In an effort to establish a central depository site for tracking of all health plan deliverables, mqdcmcs@dhs.hawaii.gov has been designated to receive all required reports. ***Electronic versions of these reports shall be submitted in the form and format approved by the MQD. All reporting data shall be submitted to the DHS in electronic format of either Word 2013 or lower (.docx), or Excel 2013 or lower (.xlsx). Reporting data shall not be submitted in .pdf files, with read only, or protected formatting. All reports shall be submitted to the MQD via the FTP server*** with the exception of the QUEST Integration Financial Reporting Guide that will **also** 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.

c: Tom Miller (HSAG)

Attachments:
QI - 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 (PAM) - (rev 11.18)
Provider Grievance and Claims Report (PGC) - (rev 11.18)
Provider Network Adequacy and GeoAccess Report (PNA) - (rev 11.18)
Suspected Fraud and Abuse Report (SFA) - (rev 11.18)

1179 – Summary of Change of Member Demographics

RFP Requirements:	***Section 51.540.7***
Report Scope:	***Monthly, reporting all activities during the report month***
Report Period(s):	***Twelve (12) one-month periods starting January and ending in 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)*** ***Example: 1179_1901, 1179_1902, 1179_1903, etc.***

Required Report Information:

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

Accreditation Update Report

RFP Requirements:	***RFP Section* 51.550.1**
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 & 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:	***ACU_1903, ACU_1906, ACU_1909, ACU_1912***

Required Report Information:

The health plan shall submit *Accreditation Updates* in which it provides updates on its progress in achieving accreditation as required in Section 51.550.1. The health plan shall obtain NCQA accreditation for its QUEST Integration program before their current accreditation expires. These updates shall detail activities undertaken and provide a synopsis of any issues that have arisen that may impede the accreditation process.

Health plans with a NCQA accreditation need to submit report originally with a copy of their NCQA accreditation.

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

***Health plans do not need to submit this report until reaccreditation occurs.**

Aid To Disabled Review Committee (ADRC) Report

RFP Requirements:	***RFP Section* 51.540.8**
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 & 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:	***ADR_1903, ADR_1906, ADR_1909, ADR_1912***

Required Report Information:

The health plan shall submit to the DHS an *Aid to Disabled Review Committee (ADRC) report.* Reports shall include information on number of ADRC referrals, number approved, number transitioned to LTSS, and number transitioned to SHOTT.

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

<u>CAHPS® Consumer Survey</u>

RFP Requirements:	***RFP Section 51.540.5***
Report Scope:	***Annually***
Report Period(s):	***If applicable***
Report Due Date(s):	***Annually, if applicable***
Report Formats:	***Copy of CAHPS survey in both hard and electronic format***
Code:	***CAHPS***

<u>Required Report Information</u>:

The health plan shall report the results of any CAHPS® Consumer Survey conducted by the health plan on Medicaid members, if applicable. The health plan shall provide a copy of the overall report of survey results to the DHS. This report is separate from any CAHPS® Consumer Survey that is conducted by the DHS.

Call Center Report

RFP Requirements:	***Section 51.540.1***
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 & October through December***
Report Due Date(s):	***Last day of the first month following the end of the reporting period***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***CCR_1903, CCR_1906, CCR_1909, CCR_1912***

Required Report Information:

The health plan shall submit a report on the utilization rate of the call center for members during the previous quarter that shall include, at a minimum, the following:

- Number of customer service call center calls received (actual number and number reported per 100 members/providers);
- Call abandoned;
- Call abandonment rate;
- Calls answered;
- Average speed of answer;
- Average hold time;
- Average handle time;
- Blocked calls;
- Blocked call rate;
- Longest wait in queue;
- Average talk time; and

- Type of call.

If approved by the DHS, the health plan may submit call center utilization using alternative methods.

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

CMS 416 Report – EPSDT

RFP Requirements:	***Section 51.530.1***
Report Scope:	***Annually, reporting all activities during the report year***
Report Period(s):	***One (1) twelve-month period for the federal fiscal year, from October 1 through September 30***
Report Due Date(s):	***Annually, February 28***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***416_19***

Required Report Information:

The plans must follow the latest CMS 416 report format and instructions when preparing this report. The QUEST Integration plans are required to have these reports reviewed by their Medical Director prior to submittal.

<u>Community Care Services (CCS) Referral Report</u>

RFP Requirements:	***RFP Section* 30.750**
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 & 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:	***CCS_1903, CCS_1906, CCS_1909, CCS_1912***

<u>Required Report Information</u>:

The health plan shall submit the Community Care Services (CCS) Referral Report quarterly. The report captures the number of CCS referrals per quarter and identifies adults with a diagnosis of serious mental illness (SMI) or serious and persistent mental illness (SPMI) who are in need of additional behavioral health services.

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

Disclosure of Information on Annual Business Transactions Report

RFP Requirements:	***Section 51.570.6***
Report Scope:	***At a minimum, annually***
Report Period(s):	***Upon contract extension or renewal;*** ***Annually (if no contract extension or renewal); and*** ***Within thirty (30) days after any change in ownership of the health plan***
Report Due Date(s):	***Annually, October 31***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***ABT_19 (Annual Report)*** ***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.

For the purposes of this section, a party in interest, as defined in Section 1318(b) of the Public Health Services Act is:

- Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;
- Any organization in which a person described above is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;
- Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or
- Any spouse, child, or parent of an individual described in the foregoing bullets.

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 disclosing entity, fiscal agent, or managed care entity. 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 disclosing entity (fiscal agent, or managed care entity) or in any subcontractor in which the disclosing entity (fiscal agent, or managed care entity) has a five percent (5%) or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (fiscal agent, or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (fiscal agent, or managed care entity) has a five percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (fiscal agent, or managed care entity) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (fiscal agent, or managed care entity).

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

Encounter Data/Financial Summary Reconciliation Report

RFP Requirements:	***Section 51.570.7***
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 & October through December***
Report Due Date(s):	***Last day of the first month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***EDR_1903, EDR_1906, EDR_1909, EDR_1912***

Instructions for submission are provided below. Health plan shall also provide any additional summaries, data, or explanations as to differences between the summary reports, and encounter data and financial summaries.

Required Report Information:

Encounter Data/Financial Summary Reconciliation Report Instruction Sheet

The following are instructions for accumulating claim data and financial information that will allow DHS and their actuaries to duplicate the process using the submitted encounter data. It will also confirm the completeness of the encounter data through the reconciliation to the financial statements.

Form A summarizes the submitted encounter data. Because of claim lag issues and in an attempt to be consistent with sources for the financial statements, encounter data is to be reported on a paid claim basis for each quarter.

1. The grouping of claims by category of service should be consistent with the approach used to complete the financial statements.
2. When counting records and utilization statistics, a claim with a negative billed amount (e.g., reversals) should be counted as negative. A claim with $0 paid (e.g., denials) would count as zero.
3. Paid amounts should be reported net of third party liability recoveries.
4. Capitated expenses may not be available at the level of detail identified on the summary report. However, these amounts should be provided on the subtotal line for each major

type of service (e.g., physician/other). Capitated records should be summarized at the procedure code grouping level.

Form B provides general guidelines for the reconciliation of the paid claim information to the incurred claims reported on the financial statements. Additional line items should be added as necessary.

1. Form B should include all items not reported in the encounter data.
2. Several specific items have been requested to clarify the extent to which health plans are reporting these items as administrative expenses or claim costs, such as case management expenses.

<u>**Encounter Data Reporting**</u>

RFP Requirements:	***RFP Section*** **51.580**
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***

Health plans are required to submit encounter data to the MQD at least once per month in accordance with the requirements and specifications defined by the State and included in the Health Plan Manual. Plans have the option to submit encounters twice a month. Encounters shall be certified and submitted by the health plans as required in 42 CFR §438.606 and as specified in Sections 51.580 and 51.620.

Reporting Timelines/Sanctions

- Health Plan will be notified within 30 days of submission or completion of accuracy edits;
- If failed, HP shall be granted a 30-day error resolution period; and
- If at the end of 30 days, the HP accuracy and completion edits fail to meet the requirements as specified in Section 51.580.1, a penalty shall be assessed.

FQHC or RHC Services Rendered Report (Quarterly/Annually)

RFP Requirements:	***Section 51.520.5***
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 & October through December***
Report Due Date(s):	***May 31, following the annual report period end*** ***The last day of the first month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***FQHA_19 (Annual Report)*** ***FQH_1903, FQH_1906, FQH_1909, FQH_1912***

Required Report Information:

Refer to the following attachment: **QI FQHC MCO Quarterly/Annual Reporting Requirements**

<u>Fraud and Abuse Summary Report</u>

RFP Requirements:	***Section 51.570.1***
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 & October through December***
Report Due Date(s):	***The last day of the first month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***FAS_1903, FAS_1906, FAS_1909, FAS_1912***

<u>Required Report Information:</u>

The health plan shall submit *Fraud and Abuse Summary Report*s 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 (or definitively) fraud or abuse and steps taken to remedy the situation;
- 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.

Going Home Plus Reports

RFP Requirements:	***Section 51.530.3***
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 & October through December***
Report Due Date(s):	***The 15th of the first month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***GHP_1903, GHP_1906, GHP_1909, GHP_1912***

Required Report Information:

On a quarterly basis, the health plan shall submit information to DHS to include but not limit to:

- Referrals;
- Ineligibles;
- Admissions;
- Reinstitutionalizations while in GHP to include hospitalization;
- Discharges (completion of 365 days);
- Emergency Department visits;
- Hospitalizations;
- Voluntary and Involuntary Disenrollments;
- Deaths;
- Type of Housing;
- Changes in Living Arrangements;
- Changes in Case Management;
- Self Direction; and
- Expenditures related to provision of services.

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

HealthCare Effectiveness Data and Information Set (HEDIS) Report

RFP Requirements:	***RFP Section* 51.550.4**
Report Scope:	***Annually, reporting all activities during the report period***
Report Period(s):	***One (1) twelve-month period, from January through December***
Report Due Date(s):	***Annually, June 15***
Report Formats:	***Electronic file in a format described by MQD***
Code:	***HED_19***

Required Report Information:

The health plan shall submit Healthcare Effectiveness Data and Information Set (HEDIS) Reports in the format provided by the DHS or the External Review Quality Organization (EQRO).

These reports shall cover the period from January 1 to December 31 and shall be reviewed by the health plan's Medical Director prior to submittal to the DHS.

The EQRO shall annually perform a HEDIS Report Validation of all State-selected HEDIS measures to ensure health plan compliance with HEDIS methodology.

Improper Payments Report

RFP Requirements:	***NA***
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 & October through December***
Report Due Date(s):	***By the 15th of each month following the report period end***
Report Formats:	***Electronic file in a format described by MQD***
Code:	***IPR_1903, IPR_1906, IPR_1909, IPR_1912***

Required Report Information:

Self-Direction expenditure report.

Interpretation/Translated Documents Report

RFP Requirements:	***Section 51.540.2and 51.540.3***
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 & October through December***
Report Due Date(s):	***The 15th of each month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***ITR_1903, ITR_1906, ITR_1909, ITR_1912***

Required Report Information:

The health plan shall submit *Translation/ Interpretation Services Reports* that include the following information on activities during the previous quarter:

- The name and Medicaid identification number for each individual to whom translation/interpretation services was provided;
- The primary language spoken by each LEP individual;
- Sign Language service provided;
- TTY/TDD services provided;
- The date of the request;
- The date provided;
- The type of translation/interpretation service provided; and
- The name of the translator/interpreter (and agency, if applicable).

The health plan shall submit *Requests for Documents in Alternative Languages Reports* that include the following information on activities during the previous quarter:

- The name and Medicaid identification number for each member requesting documents in an alternative language;

- The language requested;
- The date of the request; and
- The date the documents were mailed or provided.

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

Long-Term Services and Supports (LTSS) Report

RFP Requirements:	***Section 51.530.2***
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 & October through December***
Report Due Date(s):	***The last day of the first month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***LTSS_1903, LTSS_1906, LTSS_1909, LTSS_1912***

Required Report Information:

The health plan shall submit to the DHS a *Long-Term Services and Supports report*. Reports shall be for members that are receiving LTSS as defined in Section 40.730. Reports shall include information on services provided, assessments performed, service plan updates, addition or reduction of services, authorization of services (i.e., environmental adaptations) and any other quality measures that the DHS deems necessary.

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

Maintenance of Effort (MOE) - HCBS

RFP Requirements:	***NA***
Report Scope:	***Annually or upon request***
Report Period(s):	***One (1) twelve-month period as indication by request***
Report Due Date(s):	***Annually, January 15 or as indicated by request***
Report Formats:	***Electronic file in a format described by MQD***
Code:	***MOE_19 (Annual Report)*** ***MOE_date (Upon Request)***

Required Report Information:

Report of all Home and Community Based Services (HCBS) and At-Risk Services paid for by the health plan during the requested reporting period.

Medicaid Contracting Report

RFP Requirements:	***RFP Section 51.570.8***
Report Scope:	***Annually, reporting all activities during the report year***
Report Period(s):	***Health Plan financial year***
Report Due Date(s):	***December 31***
Report Formats:	***Electronic file in an Excel***
Code:	***MCR_19***

Required Report Information:

The health plan shall submit an annual Medicaid contracting report to DHS, the State of Hawaii Department of Commerce and Consumer Affairs Insurance Division, and the Hawaii State Legislature, no later than one-hundred eighty (180) days following the end of the State Fiscal Year (SFY). The content of the Medicaid contracting report will include the information required from the Section 103F-107, HRS.

Medical Loss Ratio Report

RFP Requirements: ***51.570.10***

Report Scope: ***Annually***

Report Period(s): ***Twelve (12) one-month periods starting January and ending in December of the report year***

Report Dues Date(s): ***The first day of the 12th month following the report period end***

Report Formats: ***Electronic file from the health plan***

Code: ***MLR_19 (Annual Report)***

Required Report Information:

The health plan shall submit an annual Medical Loss Ratio (MLR) Report in compliance with 42 CFR 4.38.8 as specified in Section 51.510. Any retroactive changes to capitation rates after the contract year end will need to be incorporated into the MLR calculation. If the retroactive capitation rate adjustment occurs after the MLR report has been submitted to DHS, a new report incorporating the change will be required to be submitted within 30 days of the capitation rate adjustment payment by DHS.

The MLR standards are to ensure the health plan is directing a sufficient portion of the capitation payments received from DHS to services and activities that improve health in alignment with DHS's mission.

See QI RFP Section 51.570.10 for reporting requirements.

Member Grievance and Appeals Report

RFP Requirements:	***Section 51.540.4***
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 & 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 health plan 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.

Newborn Enrollment Report

RFP Requirements:	***Section 30.540.2***
Report Scope:	***Monthly, reporting all activities during the report quarter***
Report Period(s):	***Twelve (12) one-month periods starting January and ending in December of the report year***
Report Due Date(s):	***The last day of the first month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***NBE_1901, NBE_1902, NBE_1903, etc.***

Required Report Information:

QUEST Integration health plans shall submit a list to MQD of any newborns that were auto-assigned to their health plan for the ***first thirty (30) days of birth*** if that child is known to have a mother with health insurance through a different issuer that also has a QUEST Integration health plan. Health plans shall submit newborns that were enrolled in their health plans no more than sixty (60) days prior to report submission. QUEST Integration health plans shall:

- Submit file via their file transfer protocol (FTP) site;
- Inform MQD that file has been submitted; and
- Include the following fields:
  - QUEST Integration Identification number;
  - Last name of newborn;
  - First name of newborn (if known);
  - Date of birth (DOB);
  - Last name of mother;
  - First name of mother; and
  - Commercial insurance.

The health plan shall utilize a format provided by the DHS.

Overpayments Report

RFP Requirements:	***51.320***
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 MCO 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 MCO shall be reported to DHS. The overpayment shall be reported in the reporting period in which the overpayment is identified. It is understood the MCO may not be able to complete recovery of overpayment until after the reporting period. The MCO must report to DHS the full overpayment identified. The MCO 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 MCO. The MCO 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 MCO will check the reporting of overpayment recoveries for accuracy and will provide an accuracy report to the DHS upon request. The MCO 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.

PCP Assignment Report

RFP Requirements:	***Section 51.520.3***
Report Scope:	***Monthly, reporting all activities during the report month***
Report Period(s):	***Twelve (12) one-month periods starting January and ending in December of the report year***
Report Due Date(s):	***The 15th of the first month following the report month***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***PCP_1901, PCP_1902, PCP_1903, etc.***

Required Report Information:

The health plan shall submit the PCP Assignment Report that provides the following information from the previous month:

- The total number of unique providers serving as a PCP to include the PCP to member ratio;
- The number and percent of members that chose or were auto-assigned to a PCP;
- The number of PCP change requests received and processed;
- The medical specialties with the largest number of PCP assignments; and
- Information on the highest utilized PCP.

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

PCP Enhancement

RFP Requirements:	***N/A***
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 & October through December***
Report Due Date(s):	***Forty-five (45) days following the report period end***
Report Formats:	***Electronic file in a format described by MQD***
Code:	***See below***

Required Report Information:

The health plans shall submit the PCP Enhancement reports to DHS in accordance to the following schedule:

1st Quarter: January – March 2019

Due Date	Content	File Name
May 15, 2019	File of all enhanced payments to PCPs in format determined by DHS	**PCPE-C_1903**

2nd Quarter: April – June 2019

Due Date	Content	File Name
August 15, 2019	File of all enhanced payments to PCPs in format determined by DHS	**PCPE-C_1906**

3rd Quarter: July – September 2019

Due Date	Content	File Name
November 15, 2019	File of all enhanced payments to PCPs in format determined by DHS	**PCPE-C_1909**

4th Quarter: October – December 2019

Due Date	Content	File Name
February 15, 2020	File of all enhanced payments to PCPs in format determined by DHS	**PCPE-C_1912**

Reports shall be submitted using the format provided by the DHS

<u>Performance Improvement Projects (PIP) Report</u>

RFP Requirements:	***RFP Section 51.550.3***
Report Scope:	***Annual***
Report Period(s):	***N/A***
Report Due Date(s):	***July 1***
Report Formats:	***Electronic file submitted to HSAG and MQD/ FTP sites***
Code:	***PIP_19***

<u>Required Report Information</u>:

Annually, the health plan shall submit two (2) *Performance Improvement Projects Reports* to the DHS and its EQRO. The report shall document a clearly defined study question, and well-defined indicators (both of which may be selected by the DHS). The reports shall also address the following elements: A correctly identified study population, valid sampling techniques, accurate/complete data collection, appropriate improvements strategies, data analysis and interpretation, reported improvements, if any, and sustained improvement over time, if any. The reports shall be independently validated by the EQRO, on an annual basis, to ensure compliance with CMS protocols, and DHS policy, including timeline requirements. Status reports on performance improvement projects may be requested more frequently by the DHS.

Prescription Drug Rebate Report

RFP Requirements:	*N/A*
Report Scope:	*Monthly, reporting all activities during the report month*
Report Period(s):	*Twelve (12) one-month periods starting January and ending in December of the report year*
Report Due Date(s):	*The 15th of the first month following the report month*
Report Formats:	*Electronic file in a format described by MQD*
Health Plan Codes:	*AlohaCare (AC) - PDR_AC1901, PDR_AC1902, PDR_AC1903, etc...* *HMSA (HM) - PDR_HM1901, PDR_HM1902, PDR_HM1903, etc...* *KAISER Permanente (KP) – PDR_KP1901, PDR_KP1902, etc...* *OHANA Health Plan (OH) – PDR_OH1901, PDR_1902, etc...* *UnitedHealthcare Community Plan (UH) – PDR_UH1901, etc...*

Each health plan shall submit on a monthly basis any new prescription drug claims to the MQD.

Prior Authorization Request Denied/Deferred Report (Medical and Pharmacy)

RFP Requirements:	***Section 51.560.1***
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 & 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:	***PAM_1903, PAM_1906, PAM_1909, PAM_1912***
	PAP_1903, PAP_1906, PAP_1909, PAP_1912

Health plans are required to correctly interpret the QUEST Integration program's benefits and appropriately apply the program's medical necessity criteria to all services requested. Report pharmaceutical and medical 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 health plan's denial or the reason(s) for deferral of the request;
- Date and method of notification of the provider of the health plan's determination; and
- Date and method of notification of the member of the health plan'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

RFP Requirements:	***Section 51.520.7***
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 & October through December***
Report Due Date(s):	***The last day of the first month following the report period end***
Report Formats:	***Electronic copy in a format described by the 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

RFP Requirements:	***Section 51.520.1 and 51.520.2***
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 & October through December***
Report Due Date(s):	***The last day of the first month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***PNA_1903, PNA_1906, PNA_1909, PNA_1912***

Each health plan must offer an appropriate range of preventive, primary care and specialty services that are adequate for an anticipated number of members and ensure that the network is sufficient to meet the member's health needs.

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;
- Number of members from its plan currently assigned to provider (PCPs only);
- Indication as to whether the provider has a limit on the number of QUEST Integration program patients he/she will accept;
- Indication as to whether the provider is accepting new patients;
- Foreign 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 the Federal or State exclusions list.
- Verification that officers/directors/anyone with a controlling interest/managing employees are not on the Federal or State exclusion list.

The health plan shall provide a narrative that describes the health plan'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 health plan 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;
- The number of providers by specialty and by location that are accepting new members with a comparison to the zip codes of members;
- Number of members from its plan that are currently assigned to the provider (PCPs only);
- Indication as to whether the provider has a limit on the number of QUEST Integration program members he/she will accept;
- Indication as to whether the provider is accepting new patients; and
- Non-English language spoken (if applicable).

The health plan 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 51.510, these reports shall be submitted to the DHS at the following times:

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

- Any time there has been a significant change in the health plan's operations that would affect adequate provider capacity and services. A significant change is defined as any of the following:
    - A decrease in the total number of PCPs by more than five percent (5%) per island (for the island of Hawaii the health plan shall report on this for East Hawaii and West Hawaii);
    - 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 Suspension and Terminations Report (three business days and quarterly), Employee Suspension and Termination Report, and Provider Education and Training Report

RFP Requirements:	***Section 51.520.6, 51.570.2, 51.570.3***
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 & October through December***
Report Due Date(s):	***The last day of the first month following the report period end***
Report Formats:	***Electronic copy in a format described by the 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 health plan has not suspended or terminated any provider during these respective periods, please report this in writing. Indicate if the plan reported the suspended and/or termination to the National Practitioner Databank. The health plan shall submit information on all providers that are denied credentialing for any reason on their quarterly report.

The health plan 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.

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.

In addition, the health plan shall submit all provider education and training relating to correct/incorrect coding, proper/improper claims submissions. The education/training can be to prevent fraud, waste and abuse or initiate by the health plan as a result of pre-payment or post-payment claims reviews. This report shall identify training/education at an individual provider level or as a group session.

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

Public Summary Report (PSR)

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 the 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:

- Member Related;
- Provider Related;
- Behavioral Health;
- Service Coordination;
- Dual Eligibles;
- Utilization Management; and
- Interpretation Requests.

The health plan shall utilize a format provided by the DHS. The PSR shall be posted on the MQD website.

Quality Assurance and Performance Improvement (QAPI) Report

RFP Requirements:	***RFP Section 51.550.2***
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 health plan shall provide an annual *QAPI Program Report*. The health plan'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 health plan'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 51.410 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 health plan'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).

QUEST Integration Dashboard

RFP Requirements:	***Section 51.570.9***
Report Scope:	***Monthly, reporting all activities during the report quarter***
Report Period(s):	***Twelve (12) one-month periods starting January and ending in December of the report year***
Report Due Date(s):	***The 15th of the first month following the report month***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***QDB_1901, QDB_1902, QDB_1903, etc.***

Required Report Information:

The health plan shall submit a monthly summary identified as the QUEST Integration Dashboard of QUEST Integration health plan performance utilizing a format provided by the DHS. Information included on the QUEST Integration Dashboard includes but is not limited to:

- Member demographics;
- Provider demographics;
- Call center statistics;
- Claims processing;
- Complaints from both member and providers; and
- Utilization data.

The health plan shall utilize a format provided by the DHS. The QUEST Integration Dashboard shall be posted on the MQD website on a monthly basis.

QUEST Integration Financial Reporting Guide

RFP Requirements:	***Section 51.570.4***
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 (Calendar) or July through June (fiscal)*** ***Four (4) three-month periods, from January through March, April through June, July through September & October through December***
Report Due Date(s):	***Annually, April 30 if using Calendar Year, or October 31 if using State Fiscal Year*** ***Quarterly, forty-five (45) days after period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***QFGA_19 (Annual Report)*** ***QFG_1903, QFG_1906, QFG_1909, QFG_1912***

Required Report Information:

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

<u>**Report of Over and Under Utilization of Drugs**</u>

RFP Requirements:	***Section 51.560.2***
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 & October through December***
Report Due Date(s):	***The last day of the first month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***OUD_1903, OUD_1906, OUD_1909, OUD_1912***

<u>Required Report Information</u>:

- Listing of the top fifty (50) high cost formulary drugs and the top fifty (50) highly utilized formulary drugs, the criteria that is used/developed to evaluate their appropriate, safe, and effective use, and the outcomes/results of the evaluations;
- Listings of the top fifty (50) highest utilized non-formulary drugs paid for by the plan including the charges and allowances for each drug as well as the criteria used/developed to evaluate the appropriate, safe and effective use of these medications and the outcomes/results of the evaluations;
- Listing of members who are high users of controlled substances but have no medical condition (i.e., malignancies, acute injuries, etc.) which would justify the high usage. Additionally, the health plan shall submit: (1) its procedures for referring these members for care coordination/case management (CC/CM) for monitoring and controlling their over-utilization, and (2) the results of the CC/CM services provided;
- Results of pharmacy audits, including who performed the audits, what areas were audited, and if problems were found, the action(s) taken to address the issue(s), and the outcome of the corrective action(s); and
- List of Hepatitis C drugs.

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

<u>Report of Over and Under Utilization of Services</u>

RFP Requirements:	***Section 51.560.3***
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 & October through December***
Report Due Date(s):	***The last day of the first month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***OUS_1903, OUS_1906, OUS_1909, OUS_1912***

<u>Required Report Information</u>:

The health plan shall submit *Reports of Over-Utilization and Under-Utilization of Services.* The reports shall include information on the following measures:

- PCP Utilization: The number and percent of members that did not have access to a PCP who have a chronic disease or have over-utilization of narcotics or other pharmaceuticals;
- Hospital Utilization: The average length of stay (LOS) in hospitals by member type and the number and percentage of members by location and diagnosis who had a readmission within the past thirty (30) days;
- Emergency Room Utilization: The number and percent of members with ER use that were not admitted to a hospital by location and diagnosis;
- Adults and Children whose utilization causes the members to be in the top two percent (2%) of all health plan members by utilization frequency and/or expenditures and increasing by one percent (1%) per year until reaching five percent (5%), expenditures over certain periods, and service coordination activities to the identified members;
- Health Care Acquired Conditions (HAC) or Other Provider Preventable Conditions (OPPC): Provide information on HAC and OPPC as described in format provided by DHS; and
- Other criteria as determined by the DHS.

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

Special Health Care Needs Report

RFP Requirements:	***RFP Section 51.540.6***
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 & 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:	***SHCN_1903, SHCN_1906, SHCN_1909, SHCN_1912***

Required Report Requirements:

The health plan shall submit to the DHS a *Special Health Care Needs (SHCN) Report*. Reports shall include a list of all new members (both children and adults) who are identified as having a SHCN as defined in Section 40.910. In addition, the health plan shall provide information on the SHCN identified, service coordination, service plan, date identified as having a SHCN and date service plan was completed over the past quarter. In addition, the health plan shall provide information on members who were previously identified as having SHCN as well as those who's SHCNs have been resolved.

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

Suspected Fraud and Abuse Report

RFP Requirements:	***RFP Section 51.320***
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_date***

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;
- Specific statutes, rules, regulations, or policies violated includes all applicable for Federal/Medicaid as well as health plan policies;
- 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

RFP Requirements:	***Section 51.570.5***
Report Scope:	***Monthly, reporting all activities during the report month***
Report Period(s):	***Twelve (12) one-month periods starting January and ending with 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 the 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 QUEST Integration members who have commercial insurance with the same or other health plan.

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

Timely Access Report

RFP Requirements:	***Section 51.520.4***
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 & October through December***
Report Due Date(s):	***The last day of the first month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***TAR_1903, TAR_1906, TAR_1909, TAR_1912***

Each health plan shall provide timely access to quality care in keeping with stated standards.

Required Report Information:

The health plan shall submit Timely Access Reports that monitor the time lapsed between a member's initial request for an appointment and the date of the appointment. The data may be collected using statistically valid sampling methods (including periodic member and provider surveys). Using data collected during the previous quarter, the report shall include the:

- Total number of appointment requests;
- Total number and percent of requests that meet the waiting time standards identified in Section 40.230 (for each provider type/class, e.g., specialists, PCP adult, PCP pediatric sick, etc.);
- Total number and percent of requests that exceed the waiting time standards (for each provider type/class);
- Average wait time for PCP routine visits; and
- Average wait time for requests that exceed the waiting time standards (for each provider type/class).

If the health plan is not meeting timely access in any one area (i.e., specialists), the DHS may require additional data collection (i.e., a report by specialty type).

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

AN EQUAL OPPORTUNITY AGENCY

Value Driven Health Care Report

RFP Requirements:	***RFP Section 51.520.8***
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 & 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:	***VHC_1903, VHC_1906, VHC_1909, VHC_1912***

Required Report Requirements:

The health plan shall submit *Value-Driven Health Care Report* that includes information on the health plan's value-driven program.

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

Summary of EQRO Activities for CY 2019:

- Validation of HEDIS measures
- Validate 2 PIPs
- Compliance Review with Standards
- Conduct CAHPS Adult Survey
- Provide technical assistance as directed by the MQD, including guidance on PIP activities, compliance, and corrective action plans.

Selected Reviews

The MQD may choose to conduct a focused review of a specific area or ask that the medical records of specific members be made available for review either on-site or a copy of the medical records be sent to the MQD and its designated contractor. When the MQD decides to review medical records, the health plans will receive notification 60 days prior to the review. These reviews may generate an on-site visit to the health plan.