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October 18, 2023

MEMORANDUM

MEMO NO.
QI-2337

TO: QUEST Integration (QI) Health Plans

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

SUBJECT: QUEST INTEGRATION (QI) TRANSITION OF CARE (TOC) FILES DURING MODIFIED ANNUAL PLAN CHANGE PERIOD

***Modified Transition of Care Requirements***

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, as a result of a plan change during the modified annual plan change (APC) period, does not result in decreased quality of care for our members.

With the goal to reduce member confusion and mailings during the ongoing Public Health Emergency Membership Redetermination period that will end in the summer of 2024, the regular APC period that occurs in October of each year will be replaced with a modified APC period. Between April 1, 2023 and July 31, 2024, all Medicaid members are allowed to change their Health Plan enrollment at any time after 12 months of membership in a particular Health Plan. Med-QUEST Division will revert to the regular APC period in October 2024.

When members change Health Plans, they will be enrolled into the new Health Plan on the first day of the following month. Members transferring to a new Health Plan, 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 contract or non-contract 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 contract Section 9.2.A.

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 an assessment by the new Health Plan as described in Section 3 of the QI contract. 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 the PCP who has authorized a course of treatment. 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 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 new Health Plan shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract) through the postpartum period, if appropriate.

***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 Health Plans, generating and receiving the TOC information. The initial enrollment choices are effective the first day of the month following member's plan change.

MQD will provide five different categories of files 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)

Please do not include any "title" rows at the top of the spreadsheet files. These files will be exchanged between the MQD and the Health Plans on the SFTP under each Health Plan's respective 'Other/HP Reports/' folder.

***Modified Transition of Care File Timeline***

| Process | Timeline (1) |
|---|---|
| Members make their APC choices (monthly from 10/1/2023 – 7/31/2024) | Last day of the month |
| HCSB sends files describing members coming and leaving are sent to QI Health Plans using MQD proprietary format (PTL). | 2 business days after the end of the month |
| QI Health Plans return to HCSB files containing TOC I data (Attachments 1 – 5). QI Health Plans to upload member's most recent HFA, Service Plan and/or Self-Direct packet, if applicable. | 7 business days after receipt of monthly PTL file from HCSB |
| HCSB to deliver TOC I data to receiving QI Health Plans. | 12 business days after receipt of monthly TOC I data files from QI Health Plans |

(1) To the extent the timeline describes a due date of a specific file on a holiday, the due date will be the following business day.

For additional assistance or questions, please send an email with the subject line 'TOC Files' to HCSBInquiries@dhs.hawaii.gov.

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 | MM/DD/YYYY |
| 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<br>Attach most recent SD packet using naming convention:<br>MedicaidID_LastName_FirstInitial_SD.pdf |
| 23 | Special Health Care Needs | Y/N | Yes/No |
| 24 | If Y to 19, 21, 22, or 23, identify if member has an HFA/SP | Y/N | Yes/No<br>Attach most recent HFA and Service Plan using naming convention:<br>MedicaidID_LastName_FirstInitial_HFA.pdf<br>MedicaidID_LastName_FirstInitial_SP.pdf |
| 25 | History of Transplant | Y/N | Yes/No |

**Specific Guidelines**

(a) Time Frame: The latest file available.

(b) Send file as an Excel worksheet, version 2021 or lower.

**ATTACHMENT 2**

Paid Medical Claims

| # | Field Name | Type | Description |
|---|---|---|---|
| 1 | Medicaid 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 | MM/DD/YYYY |
| 15 | Service to date | date | MM/DD/YYYY |
| 16 | Paid date | date | MM/DD/YYYY |
| 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 | only valid CPT/HCPCS codes |
| 25 | Modifier 1 | text | First modifier, only valid modifier codes |
| 26 | Modifier 2 | text | Second modifier, only valid modifier codes (if applicable) |
| 27 | Modifier 3 | text | Third modifier, only valid modifier codes (if applicable) |
| 28 | Modifier 4 | text | Fourth modifier, only valid modifier codes (if applicable) |
| 29 | Modifier 5 | text | Fifth modifier, only valid modifier codes (if applicable) |

| | | | |
|---|---|---|---|
| 30 | Quantity | num | no comma, no decimal |
| 31 | Revenue code | text | UB claims only, 4 character w/leading 0 |

**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 for the last 6 months of member's enrollment.

(d) Send the latest version of a claim.

(e) Send file as an Excel worksheet, version 2021 or lower.

**ATTACHMENT 3**

Paid Pharmacy Claims

| # | Field Name | Type | Description |
|---|---|---|---|
| 1 | Medicaid 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 | MM/DD/YYYY |
| 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 pharmacy claims; no denied claims.

(c) Time Frame: Service dates for the last 6 months of member's enrollment.

(d) Send the latest version of a claim.

(e) Send file as an Excel worksheet, version 2021 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 To Provider Last Name | text | If facility or agency include name here |
| 8 | Referring To Provider First Name | text | |
| 9 | Referring To Provider 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 the last day of the enrollment month.

(c) Send file as an Excel worksheet, version 2021 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 | MM/DD/YYYY |
| 4 | End Date | date | MM/DD/YYYY |
| 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 | 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 | CPT/HCPCS | text | If applicable |
| 15 | Modifier 1 | text | First modifier, only valid modifier codes |
| 16 | Modifier 2 | text | Second modifier, only valid modifier codes (if applicable) |
| 17 | Modifier 3 | text | Third modifier, only valid modifier codes (if applicable) |
| 18 | Modifier 4 | text | Fourth modifier, only valid modifier codes (if applicable) |
| 19 | Modifier 5 | text | Fifth modifier, only valid modifier codes (if applicable) |
| 20 | Allowed Units | num | no comma, no decimal |
| 21 | Used Units | num | no comma, no decimal |
| 22 | NDC | text | No dashes |
| 23 | Drug name | text | If applicable |
| 24 | Days Supply | num | If applicable |
| 25 | Quantity | num | If applicable. No commas, no decimals. |
| 26 | Acute Hospitalization | Y/N | Yes/No |
| 27 | If Yes, Hospital Name | text | Facility name |

| | | | |
|---|---|---|---|
| 28 | Date of admission | date | MM/DD/YYYY |
| 29 | Anticipated date of discharge, if unknown, leave blank | date | MM/DD/YYYY |

**Specific Guidelines**

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

(b) Time Frame: Prior Authorizations open as of the last day of the enrollment month.

(c) Send file as an Excel worksheet, version 2021 or lower.