JOSH GREEN, M.D.
GOVERNOR
KE KIA'ĀINA

RYAN I. YAMANE
DIRECTOR
KA LUNA HO'OKELE

JOSEPH CAMPOS II
DEPUTY DIRECTOR
KA HOPE LUNA HO'OKELE

TRISTA SPEER
DEPUTY DIRECTOR
KA HOPE LUNA HO'OKELE

STATE OF HAWAII
KA MOKU'ĀINA O HAWAI'I
DEPARTMENT OF HUMAN SERVICES
KA 'OIHANA MĀLAMA LAWELAWE KANAKA
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

October 3, 2024

MEMORANDUM

MEMO NO.
QI-2419

TO: QUEST Integration (QI) Health Plans

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

SUBJECT: QUEST INTEGRATION (QI) ROLLING PLAN CHANGE AND TRANSITION OF CARE (TOC) FILES

The purpose of this memorandum is to inform the QI Health Plans of a change to Med-QUEST Division's (MQD) member plan change period. The guidelines and procedures in this memorandum are designed to ensure that the transition of QI members from one Health Plan to another Health Plan, as a result of a Rolling Plan Change, does not result in quality of care issues or gaps for our members.

Rolling Plan Change

In 2023, MQD replaced the Annual Plan Change period with a Modified Plan Change period. Since April 1, 2023, all QI members were allowed to change their Health Plan enrollment at any time without cause, after twelve (12) months of continuous membership in a particular Health Plan.

Effective immediately, MQD will continue with the Modified Plan Change period which will now be known as a Rolling Plan Change (RPC) period. When a QI member changes their Health Plan, the Health Plan enrollment choice is effective the first day of the month following the member's plan change. For example, if a member requests to change their Health Plan anytime in August, their enrollment with the new Health Plan will be effective September 1.

MQD is in the process of modifying the enrollment effective date when a QI member changes their Health Plan, with the goal of making the Health Plan enrollment choice effective the first day of the second month following the member's plan change. After this modification and as an example, if a member requests to change their Health Plan anytime in August, their enrollment with the new Health Plan will be effective October 1. MQD will issue an addendum memo to inform Health Plans of the effective date for this modification.

Transition of Care Requirements

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 members 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

Beginning October 1, 2024, MQD will be initiate the Transition of Care (TOC) process by sending out files containing the member gains and losses to the QI Health Plans. QI Health Plans will then generate the Transition of Care (TOC) files for their member losses – one file per gaining plan per file category – and upload these files to the MQD's secured sFTP site. MQD' will then move the TOC files to the gaining QI Health Plan's sFTP site.

The Health Plans shall provide five different categories of files:

- 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 MQD and the QI Health Plan's on MQD's secured sFTP site under each Health Pan's respective 'Other/HP Reports/' folder.

Transition of Care File Timeline

Process	Timeline (1)
Members make their Rolling Plan Change choice	Up to the last day of the month
MQD uploads each QI Health Plan's spreadsheet identifying the member gains and losses to MQD's secured sFTP site.	2 business days after the end of the month
QI Health Plans create TOC files for their member losses and upload it to MQD's secured sFTP site: • Attachments 1 – 5 • Member's most recent HFA, Service Plan and/or Self-Direct packet, if applicable	7 business days after receipt of gains/losses spreadsheet from MQD
MQD moves the TOC files into the gaining QI Health Plan's sFTP folder.	2 business days after the receipt of TOC files from Health Plans

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

The Health Plans shall follow the additional TOC files guidelines below:

- Use standardized TOC attachment templates.
- Combine the TOC files (Attachments 1-5) and assessment files (HFA, SP, SD) in one zipped file for each gaining Health Plan using the following naming convention: TOC_From_HP_to_HP_Eff_YYYYMM.

- Ensure that each column for all the TOC Attachment spreadsheets follow the format provided in the 'Type' column.
- Follow the date and/or text formats in the 'Description' column of each TOC Attachment, if provided.

QI Health Plans will be required to work directly plan-to-plan if there are questions or inquiries related to TOC files.

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	MemberMedicaid	text	Medicaid ID As Assigned by DHS
2	MemberLName	text	
3	MemberFName	text	
4	MemberMI	text	If available
5	MemberDOB	date	MM/DD/YYYY
6	MemberGender	text	
7	PCP_NPI	text	
8	PCP_LName	text	
9	PCP_FName	text	
10	PCP_MI	text	If available
11	PCP_Specialty	text	
12	PCP_Address1	text	
13	PCP_Address2	text	
14	PCP_City	text	
15	PCP_State	text	
16	PCP_Zip	text	
17	MedicareTPL	text	Yes/No
18	HICN	text	Medicare Beneficiary Identifier (MBI)
19	ReceivingLTSS	text	Yes/No
20	CostShare	text	Yes/No
21	AtRisk	text	Yes/No
22	SelfDirect	text	Yes/No Attach most recent SD packet using naming convention: MedicaidID_LastName_FirstInitial_SD.pdf
23	SHCN	text	Yes/No
24	HFA_SP	text	Yes/No If Y to 19, 21, 22, or 23, identify if member has an HFA/SP. Attach most recent HFA and Service Plan using naming convention: MedicaidID_LastName_FirstInitial_HFA.pdf MedicaidID_LastName_FirstInitial_SP.pdf
25	HistoryOfTransplant	text	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	MemberMedicaid	text	Medicaid ID As Assigned by DHS
2	ClaimID	text	Health Plan's claim ID
3	DetailClaimID	text	Health Plan's detail claim ID
4	FormType	text	Either HCFA or UB
5	ServiceProviderID	text	NPI
6	ServiceProviderLName	text	If facility include name here
7	ServiceProviderFName	text	
8	ServiceProviderMI	text	If available
9	ServiceProviderAddress1	text	
10	ServiceProviderAddress2	text	
11	ServiceProviderCity	text	
12	ServiceProviderState	text	
13	ServiceProviderZip	text	
14	ServiceFromDate	date	MM/DD/YYYY
15	ServiceToDate	date	MM/DD/YYYY
16	PaidDate	date	MM/DD/YYYY
17	PrimaryDiagnosis	text	no decimal
18	Diagnosis2	text	no decimal
19	Diagnosis3	text	no decimal
20	Diagnosis4	text	no decimal
21	TotalCharged	num	two decimal places, no dollar sign ($)
22	BillType	text	UB claims only
23	PlaceOfService	text	HCFA claims only
24	CPT_HCPCS	text	only valid CPT/HCPCS codes
25	Modifier1	text	First modifier, only valid modifier codes
26	Modifier2	text	Second modifier, only valid modifier codes (if applicable)
27	Modifier3	text	Third modifier, only valid modifier codes (if applicable)
28	Modifier4	text	Fourth modifier, only valid modifier codes (if applicable)
29	Modifier5	text	Fifth modifier, only valid modifier codes (if applicable)

30	Quantity	num	no comma, no decimal
31	RevenueCode	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	MemberMedicaid	text	Medicaid ID As Assigned by DHS
2	ClaimID	text	Health Plan's claim ID
3	PrescriberProviderID	text	NPI
4	PrescriberProviderLName	text	If facility include name here
5	PrescriberProviderFName	text	
6	PrescriberProviderMI	text	If available
7	PharmacyProviderID	text	NPI
8	PharmacyProviderName	text	If facility include name here
9	DispenseDate	date	MM/DD/YYYY
10	TotalSubmittedCost	num	two decimal places, no dollar sign ($)
11	TotalAllowedCost	num	two decimal places, no dollar sign ($)
12	NDC	text	No dashes
13	DrugName	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
1	MemberMedicaid	text	Medicaid ID As Assigned by DHS
2	ReferringFromProviderID	text	NPI
3	ReferringFromProviderLName	text	If facility include name here
4	ReferringFromProviderFName	text	
5	ReferringFromProviderMI	text	If available
6	ReferringToProviderID	text	NPI
7	ReferringToProviderLName	text	If facility or agency include name here
8	ReferringToProviderFName	text	
9	ReferringToProviderMI	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	MemberMedicaid	text	Medicaid ID As Assigned by DHS
2	PrimaryDiagnosis	text	no decimal
3	StartDate	date	MM/DD/YYYY
4	EndDate	date	MM/DD/YYYY
5	ServiceProviderID	text	NPI (preferred) or HI Medicaid Provider ID. If self-directed provider, include SD in this field.
6	ServiceProviderLName	text	If facility include name here
7	ServiceProviderFName	text	
8	ServiceProviderMI	text	If available
9	ServiceProviderAddress1	text	
10	ServiceProviderAddress2	text	
11	ServiceProviderCity	text	
12	ServiceProviderState	text	
13	ServiceProviderZip	text	
14	CPT_HCPCS	text	If applicable
15	Modifier1	text	First modifier, only valid modifier codes
16	Modifier2	text	Second modifier, only valid modifier codes (if applicable)
17	Modifier3	text	Third modifier, only valid modifier codes (if applicable)
18	Modifier4	text	Fourth modifier, only valid modifier codes (if applicable)
19	Modifier5	text	Fifth modifier, only valid modifier codes (if applicable)
20	AllowedUnits	num	no comma, no decimal
21	UsedUnits	num	no comma, no decimal
22	NDC	text	No dashes
23	DrugName	text	If applicable
24	DaysSupply	num	If applicable
25	Quantity	num	If applicable. No commas, no decimals.
26	AcuteHospitalization	text	Yes/No
27	HospitalName	text	If Yes, Facility name

28	AdmissionDate	date	MM/DD/YYYY
29	AnticipatedDischargeDate	date	MM/DD/YYYY If unknown, leave blank

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.