LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

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

January 16, 2009

MEMORANDUM

ACS M09-01

TO: All Medicaid Certified Nursing Facilities

FROM: Kenneth S. Fink, MD, MGA, MPH

SUBJECT: CHANGES IN COMPLETING THE MEDICAID CENSUS REPORT

On February 1, 2009, the Med-QUEST Division (MQD) will be implementing the QUEST Expanded Access (QExA) program for clients who are 65 years or older and disabled of all ages, commonly called the aged, blind or disabled (ABD) population. Individual(s) who complete the Medicaid Census Report for the nursing facilities will need to include all eligible Medicaid residents' movements upon discovery.

In the past, MQD required facilities to report monthly movement information on a resident for whom Medicaid was currently the primary insurer/biller (i.e. reported to MQD after a Medicare stay or change in level of care to intermediate care). Now, ***if the resident has Medicare and Medicaid***, the facility will need to report these Medicaid resident's movement(s) upon discovery. If the resident is a "pending Medicaid applicant", continue to report these residents after they have obtained a Medicaid number. Attached you will find a sample of this report.

If there are any questions, please contact Ms. Kathleen Ishihara, Nurse Consultant at (808) 692-8159.

Attachment

CENSUS REPORT

Medicaid Resident Movement

FACILITY NAME	PERIOD COVERED
QExA Facility	1-Feb-09
	mm/dd/yy mm/dd/yy

TYPE OF REPORT (Check only one) X **MONTHLY** ___ **QUARTERLY**

GENERAL INSTRUCTIONS:

- ☐ Please PRINT/TYPE all information.
- ☐ Submit a Monthly report each month.
- ☐ Reports due by 15 of following month.
- ☐ Submit Monthly and Quarterly (an alphabetical list) of all Medicaid residents in house on March 31, June 30, September 30, and December 31.

FOR MONTHLY

MEDICAID RESIDENT (Last Name, First Name)	MEDICAID ID NO.	ADMISSION DATE To Facility	ADMISSION DATE To Medicaid	LOA	D	E	Date of Action*	REMARKS**
Doe, Jane	000XXXXXXX	1/15/2009	2/1/2009	C				Admission to Medicare/Medicaid
Doe, John	000XXXXXXX	1/15/2009	2/15/2009	A				Admission to Medicaid from HMSA - Federal Plan
Aloha, Jane	00XXXXXXXX	1/15/2009	2/1/2009	A				Admission to Medicaid from Private Pay
Mahalo, John	00XXXXXXXX	1/28/2009	2/1/2009	A		x	2/20/2009	Admission to Medicare/Medicaid and Expired on 02/20/09

THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE FOR THE REPORTING PERIOD

Signature/Title Date

* DATE OF ACTION for Level of Acuity (LOA) Change, Discharge(D) or Expiration(E).

** REMARKS, ie, Admit from, Discharge to, LOA change (A = ICF, B = ICF/MR, C = SNF)

DHS 1137 (Rev. 11/96)