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April 27, 2010

MEMORANDUM

QExA MEMO
RPTX -1002

TO: QExA Health Plans

FROM: Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

SUBJECT: ANNUAL REPORTING AND MONITORING ACTIVITIES
PERIOD: July 1, 2009 – JUNE 30, 2010

Annually, the Med-QUEST Division's (MQD's) Clinical Standards Office (CSO), the 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 *July 1, 2009 and continue through June 30, 2010.*

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 published on June 14, 2003 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 30.920). The QExA 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, QExA 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 our 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 51.310).

When the MQD and/or the EQRO request policies and procedures (P & P's), 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 51.500).

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. 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 71.320).

In an effort to establish a central depository site for tracking of all health plan deliverables, we have designated Grant Shiira, gshiira@medicaid.dhs.state.hi.us as the key staff member to receive all required reports. ***Electronic versions of these reports shall be submitted in the form and format approved by the MQD, and shall be submitted to the MQD via the FTP server*** with the exception of the QExA Financial Reporting Guide which will 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.

Accreditation Update

RFP Requirements:	***Section 51.360.1***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March and April through June***
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:	***ACU_0910, ACU_1001, ACU_1004, ACU_1007***

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 50.510 of the QExA RFP. The health plan shall obtain NCQA or URAC or AAAHC accreditation for its QExA program by January 1, 2012. These updates shall detail activities undertaken and provide a synopsis of any issues that have arisen that may impede the accreditation process.

Annual Report of Services Rendered to Member by an FQHC or RHC

RFP Requirements:	***Section 51.320.5***
Report Scope:	***Annually, reporting all activities during the report year***
Report Period(s):	***One (1) twelve month period, from January through December*** ***Four (4) three-month periods, from July through September, October through December, January through March and April through June***
Report Due Date(s):	***May 31st, 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_0912 (annual report)*** ***FQH_0910, FQH _0912, FQH_1003, FQH_1006***

Required Report Information:

Refer to the following pages entitled: **"DHS QUEST Financial Summary File for FQHC and RHC."**

Department of Human Services
QUEST

Financial Summary File

Federally Qualified Health Centers (FQHC)
Rural Health Clinics (RHC)

General Report Description	
Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Services	
Purpose	Financial Summary Information for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) including incentive, capitation, administrative and fee for service payments. Submit one report to include all providers of this type. The data will be utilized to identify any supplemental payments that may be required of the Hawaii Department of Human Services to the in-network and out-of-network FQHC or RHC to ensure that the FQHC or RHC receives reimbursement for the services rendered to the MCO's members equal to the amount the provider is entitled to under the Benefits Improvements and Protection Act of 2000 (BIPA).
Preferred Submission Type	Excel .xls file
Comments	**Quarterly:** This financial summary data must be submitted by the MCO to DHS no later than 30 calendar days after the end of each quarter. **Annually:** This financial summary data must be submitted by the MCO to DHS no later than 150 calendar days after the end of each calendar year. The MCO should submit the data file for all FQHC/RHC providers as follows: Accumulate all data based on date of service. **For Fee-For-Service based payments**, information on all claims for services paid during the time period specified on the report. Paid claims are to include reversals, voids and or adjustments. Note: The sum of FFS payments (Data Element 13 and 14) must equal the respective detail claims/encounter data file. **For all capitation based payments**, information on all claims for services paid and encounters set to "final adjudication" during the time period specified on the report. All performance incentives (excluding dollars paid as capitation or fee-for-service reimbursement) which accrued or was paid during the reporting period. Total capitation payments made to the provider for the reporting period. Total administrative fees paid

Department of Human Services
QUEST

Financial Summary File

Federally Qualified Health Centers (FQHC)
Rural Health Clinics (RHC)

Data Elements		
1.) MCO ID	Insert the MCO identification number	12 Character Length
2.) MCO Name	Insert the MCO Name	45 Character Length
3.) Report Date	Indicate the date the report data was generated from the management information system.	Enter MM/DD/YYYY format (10 character length)
4.) Provider Number	Insert the Medicaid Provider identification number identified in item 4 "FQHC/RHC Provider Name".	12 Character Length
5.) Provider Name	Indicate the name of the FQHC or RHC on which the MCO is reporting.	45 Character Length
6.) Begin Period	Indicate the beginning date of the reporting period for which the MCO is submitting the report.	Enter MM/DD/YYYY format (10 character length)
7.) End Period	Indicate the ending date of the reporting period for which the MCO is submitting the report.	Enter MM/DD/YYYY format (10 character length)
8.) Count of FFS claims/encounters	Enter the count of Fee-For-Service paid claims/encounters.	Enter in 999,999,999 format (11 character length)
9.) Count of CAP claims/encounters	Enter the count of Capitation paid claims/encounters.	Enter in 999,999,999 format (11 character length)
10.) CAP Payments	Enter the capitated paid amount.	Enter in 999,999,999.99- format (15 character length)
11.) Admin Fees	Enter the amount of paid administrative fees.	Enter in 999,999,999.99- format (15 character length)
12.) Incentive Payments	Enter the total amount paid for incentives.	Enter in 999,999,999.99- format (15 character length)
13.) Primary FFS Payments	Enter the Fee-For-Service paid amount for claims in which Medicaid was the primary payer.	Enter in 999,999,999.99- format (15 character length)
14.) Secondary FFS Payments	Enter the Fee-For-Service paid amount for claims in which Medicaid was the secondary payer.	Enter in 999,999,999.99- format (15 character length)
15.) Total Payments	Enter the Sum of CAP Payments, Admin Fees, FFS Payments and Incentive Payments.	Enter in 999,999,999.99- format (15 character length)

Department of Human Services
QUEST

Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Primary
Rural Health Clinics (RHC) - Medicaid Primary

General Report Description	
Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Medicaid Primary Services	
Purpose	Medicaid Primary Detail Claims and Encounter Services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Submit one report per provider The data will be utilized to identify any supplemental payments that may be required of the Hawaii Department of Human Services to the in-network and out-of-network FQHC or RHC to ensure that the FQHC or RHC receives reimbursement for the services rendered to the MCO's members equal to the amount the provider is entitled to under the Benefits Improvements and Protection Act of 2000 (BIPA).
Preferred Submission Type	ASCII Fixed Width Text File
Comments	**Quarterly:** This financial summary data must be submitted by the MCO to DHS no later than 30 calendar days after the end of each quarter. **Annually:** This financial summary data must be submitted by the MCO to DHS no later than 150 calendar days after the end of each calendar year. The MCO should submit the data file for all FQHC/RHC providers as follows: **Include the line level detail of all claims in which Medicaid is the primary payer.** **For Fee-For-Service based FQHC/RHC claims payments**, information on all claims for services paid during the time period specified on the report. Paid claims are to include reversals, voids and or adjustments. **For all capitated based FQHC/RHC claims payments**, information on all claims for services paid and encounters set to "final adjudication" during the time period specified on the report.

Department of Human Services
QUEST

Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Primary
Rural Health Clinics (RHC) - Medicaid Primary

Data Elements		
1.) Item No.	Consecutively number each member item for the report.	Consecutive number beginning with 1 (6 Character Length)
2.) MCO ID	Insert the MCO identification number	12 Character Length
3.) MCO Name	Insert the MCO Name	45 Character Length
4.) Report Date	Indicate the date the report data was generated from the management information system.	Enter MM/DD/YYYY format (10 character length)
5.) Billing Provider Number	Insert the Medicaid Provider identification number.	12 Character Length
6.) Billing Provider Name	Insert the name of the billing FQHC/RHC on which the MCO is reporting.	45 Character Length
7.) Rendering Provider Number	Insert the identification number of the rendering provider listed on the claim.	12 Character Length
8.) Rendering Provider Name	Insert the name of the rendering provider listed on the claim.	45 Character Length
9.) Begin Date	Indicate the beginning date of the claim/encounter.	Enter MM/DD/YYYY format (10 character length)
10.) End Date	Indicate the ending date of the claim/encounter.	Enter MM/DD/YYYY format (10 character length)
11.) Member First Name	Indicate the member's first name as listed on the referenced claim item.	25 Character Length
12.) Member Last Name	Indicate the member's last name as listed on the referenced claim item.	25 Character Length
13.) Member ID Number	Insert the member's Medicaid identification number that is associated with the reported claim.	12 Character Length
14.) Patient Account Number	Identify the billing provider patient account number being submitted for the report.	20 Character Length
15.) Claim Status	Identify the status of the claim (paid, denied, pending, reversal, void, adjustment, etc.)	20 Character Length

Department of Human Services
QUEST

Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Primary
Rural Health Clinics (RHC) - Medicaid Primary

16.) Claim Number	Identify the claim identification number being submitted for the report.	30 Character Length
17.) Claim Number Detail Line	Insert the numeric detail line number of the claim.	12 Character Length
18.) Place of Service Code	Insert the place of service code.	12 Character Length
19.) Procedure Code	Insert the procedure code as listed for the detail line number on the claim.	7 Character Length
20.) Procedure Code Description	Insert the procedure code description for the detail line number on the claim.	45 Character Length
21.) Diagnosis Code	Insert the diagnosis code as listed for the detail line number on the claim.	10 Character Length
22.) Date Paid	Indicate the date the submitted claim was adjudicated as "paid".	Enter MM/DD/YYYY format (10 character length)
23.) Billed Amount	Indicate the billed amount of the detail line number of the claim	Enter in 999,999,999.99- format (15 character length)
24.) Co-Payment	Enter the portion of the medical expense that the member was responsible for.	Enter in 999,999,999.99- format (15 character length)
25.) Third Party Liability	Enter the portion of the medical expense that a third party was responsible for.	Enter in 999,999,999.99- format (15 character length)
26.) Paid Amount	Indicate the paid amount of the detail line number of the claim.	Enter in 999,999,999.99- format (15 character length)

Department of Human Services
QUEST

Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Secondary (Dual Eligibles)
Rural Health Clinics (RHC) - Medicaid Secondary (Dual Eligibles)

General Report Description	
Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Medicaid Secondary Services	
Purpose	Medicaid Secondary Detail Claims and Encounter Services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Submit one report per provider The data will be utilized to identify any supplemental payments that may be required of the Hawaii Department of Human Services to the in-network and out-of-network FQHC or RHC to ensure that the FQHC or RHC receives reimbursement for the services rendered to the MCO's members equal to the amount the provider is entitled to under the Benefits Improvements and Protection Act of 2000 (BIPA).
Preferred Submission Type	ASCII Fixed Width Text File
Comments	**Quarterly:** This financial summary data must be submitted by the MCO to DHS no later than 30 calendar days after the end of each quarter. **Annually:** This financial summary data must be submitted by the MCO to DHS no later than 150 calendar days after the end of each calendar year. The MCO should submit the data file for all FQHC/RHC providers as follows: **Include the line level detail of all claims in which Medicaid is the secondary payer.** **For Fee-For-Service based FQHC/RHC claims payments**, information on all claims for services paid during the time period specified on the report. Paid claims are to include reversals, voids and or adjustments. **For all capitated based FQHC/RHC claims payments**, information on all claims for services paid and encounters set to "final adjudication" during the time period specified on the report.

Department of Human Services
QUEST

Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Secondary (Dual Eligibles)
Rural Health Clinics (RHC) - Medicaid Secondary (Dual Eligibles)

Data Elements		
1.) Item No.	Consecutively number each member item for the report.	Consecutive number beginning with 1 (6 Character Length)
2.) MCO ID	Insert the MCO identification number	12 Character Length
3.) MCO Name	Insert the MCO Name	45 Character Length
4.) Report Date	Indicate the date the report data was generated from the management information system.	Enter MM/DD/YYYY format (10 character length)
5.) Billing Provider Number	Insert the Medicaid Provider identification number.	12 Character Length
6.) Billing Provider Name	Insert the name of the billing FQHC/RHC on which the MCO is reporting.	45 Character Length
7.) Rendering Provider Number	Insert the identification number of the rendering provider listed on the claim.	12 Character Length
8.) Rendering Provider Name	Insert the name of the rendering provider listed on the claim.	45 Character Length
9.) Begin Date	Indicate the beginning date of the claim/encounter.	Enter MM/DD/YYYY format (10 character length)
10.) End Date	Indicate the ending date of the claim/encounter.	Enter MM/DD/YYYY format (10 character length)
11.) Member First Name	Indicate the member's first name as listed on the referenced claim item.	25 Character Length
12.) Member Last Name	Indicate the member's last name as listed on the referenced claim item.	25 Character Length
13.) Member ID Number	Insert the member's Medicaid identification number that is associated with the reported claim.	12 Character Length
14.) Patient Account Number	Identify the billing provider patient account number being submitted for the report.	20 Character Length
15.) Claim Status	Identify the status of the claim (paid, denied, pending, reversal, void, adjustment, etc.)	20 Character Length

Department of Human Services
QUEST

Claim/Encounter Detail File

Federally Qualified Health Centers (FQHC) - Medicaid Secondary (Dual Eligibles)
Rural Health Clinics (RHC) - Medicaid Secondary (Dual Eligibles)

16.) Claim Number	Identify the claim identification number being submitted for the report.	30 Character Length
17.) Claim Number Detail Line	Insert the numeric detail line number of the claim.	12 Character Length
18.) Place of Service Code	Insert the place of service code.	12 Character Length
19.) Procedure Code	Insert the procedure code as listed for the detail line number on the claim.	7 Character Length
20.) Procedure Code Description	Insert the procedure code description for the detail line number on the claim.	45 Character Length
21.) Diagnosis Code	Insert the diagnosis code as listed for the detail line number on the claim.	10 Character Length
22.) Date Paid	Indicate the date the submitted claim was adjudicated as "paid".	Enter MM/DD/YYYY format (10 character length)
23.) Billed Amount	Indicate the billed amount of the detail line number of the claim	Enter in 999,999,999.99- format (15 character length)
24.) Co-Payment	Enter the portion of the medical expense that the member was responsible for.	Enter in 999,999,999.99- format (15 character length)
25.) Third Party Liability	Enter the portion of the medical expense that a third party was responsible for.	Enter in 999,999,999.99- format (15 character length)
26.) Paid Amount	Indicate the paid amount of the detail line number of the claim.	Enter in 999,999,999.99- format (15 character length)

Call Center Report

RFP Requirements:	***Section 51.350.1***
Report Scope:	***Monthly, reporting all activities during the report month***
Report Period(s):	***Twelve (12) one-month periods starting July of this year and ending with June of next year***
Report Due Date(s):	***The 15th of each month***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***CCR_(YY,MM) Ex: CCR_0907***

Required Report Information:

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

- Number of hotline calls (actual number and number reported per 1,000 members);
- Call abandonment rate;
- Longest wait in queue;
- Average talk time; and
- Type of call.

CMS 416 Report- EPSDT

RFP Requirements:	***Section 51.340.5***
Report Scope:	***Semi-annually, reporting all activities during the report period***
Report Period(s):	***Two (2) six month periods, from January through June (Due August 1) and July through December (Due February 1)***
Report Due Date(s):	***February 1, August 1***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***416_0906, 416_0912, 416_1006***

Required Report Information:

The health plan shall submit *CMS 416 Reports* that measure and document screening and participation rates in the EPSDT program. In addition to the requirements in the CMS 416 Report, the health plan shall report on any additional data that the DHS has determined is necessary for monitoring and compliance purposes.

The health plan's medical director shall review this report prior to submission to the DHS.

Disclosure of Info on Annual Business Transaction

RFP Requirements:	***Section 51.380.4***
Report Scope:	***Annually, reporting all activities during the report year***
Report Period(s):	***One (1) twelve month period, from July through June***
Report Due Date(s):	***The last day of the second month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***ABT_0906, ABT 1006***

Required Report Information:

The health plan shall submit *Disclosure of Information on Annual Business Transactions* Reports that disclose information on the following types of transactions:

- Any sales, exchanges, or lease of any property between the health plan and a party in interest;
- 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. This does not include salaries paid to employees for services provided in the normal course of their employment.

The health plan shall include the following information regarding the transactions listed above.

- The name of the party in interest for each transaction;
- A description of each transaction and the quality or units involved;
- The accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

Encounter Data/ Financial Summary Reconciliation Report

RFP Requirements:	***Section 51.380.5***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March, and April through June***
Report Due Date(s):	***Last day of the third month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***EFR_0910, EFR_1001, EFR_1004, EFR_1007***

Required Report Information:

The health plan shall submit *Encounter Data/Financial Summary Reconciliation Reports* using the instructions and format provided by the DHS. For reference, the QUEST Encounter Data/ Financial Summary Reconciliation Report and instructions are included in the documentation library located at www.med-quest.us.

Fraud and Abuse Summary Report

RFP Requirements:	***Section 51.380.1***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March and April through June***
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_0910, FAS_1001, FAS_1004, FAS_1007***

All incidences of suspected fraud and abuse identified at the health plan level must be reported to the MQD.

Required Report Information:

- Source of Complaint;
- Alleged persons or entities involved;
- Nature of complaint;
- Approximate dollars involved;
- Date of the complaint;
- Disciplinary action imposed;
- Administrative disposition of the case;
- Investigative activities, corrective actions, prevention efforts, and results; and
- Trending and analysis as it applies to: utilization management, claims management, post-processing review of claims, and provider profiling.

GeoAccess or Similar Report

RFP Requirements:	***Section 51.320.2***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March and April through June***
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:	***GAR_0910, GAR_1001, GAR_1004, GAR_1007***

Required Report Information:

The health plan shall submit reports using GeoAccess or similar software that allow the State to analyze, at a minimum, the following:

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

In addition to the due date identified above, 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 impact 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 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.

HCBS Report

RFP Requirements:	***Section 51.340.3***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March and April through June***
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:	***HCBS_0907, HCBS_0910, HCBS_1001, HCBS_1004, HCBS_1007***

Required Report Information:

The health plan shall submit to the DHS on a quarterly basis *HCBS Reports* that include the following information:

- The names of members on the waiting list;
- The date the members names were placed on the waiting list;
- The specific service(s) needed by the member;
- Progress notes on the status of providing needed service(s) to the member;
- Names of members with authorization for coverage of 1) environmental accessibility adaptations; 2) moving assistance; 3) specialized medical equipment, orthotics or prosthetics that require personalized fitting or customization specific to the member; or 4) out-of-network elective procedures, including out-of-state procedures to include date of authorization and summary of status of implementation of services;
- Names of members assessed to need HCBS since previous quarter and the specific services assessed to need; and
- Names of members assessed to need HCBS since previous quarter who are receiving the services.

Health Plan Employer Data and Information Set (HEDIS) Report

RFP Requirements:	***Section 51.360.9***
Report Scope:	***Annually, reporting all activities during the report period***
Report Period(s):	***One (1) twelve month period, from January 1 through December 31***
Report Due Date(s):	***June 15, 2010***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***HED_0912***

Required Report Information:

Two quick reminders:

1. The Med-QUEST has moved to a calendar year reporting cycle – January 1 through December 31 for the QExA HEDIS reports.

2. The Med-QUEST has moved to a concurrent review period.

The HEDIS report covering the Calendar Year 2009 period February 1, 2009 through December 31, 2009 will be due by **June 15, 2010**.

Use the HEDIS 2010 measures for the Calendar Year 2009 period. A list of measures you will be expected to submit for the Calendar Year 2009 period will be distributed under separate cover. All measures listed need to be submitted by each plan.

The reporting template will follow in mid to late December 2009. It is required that the plans report the number of the total eligible populations for all hybrid measures reported to the MQD.

Please have your Medical Director review the report prior to submittal to the MQD. If problems or questions are identified by your Medical Director or plan staff, redo the measure(s), and inform the MQD of the measure(s) being redone. All redone measures will be due to the MQD by **July 15, 2010**.

In the Spring of 2010, HSAG will perform a concurrent HEDIS Report Validation Activity on the Calendar Year 2009 period which will focus on 6 measures selected by the MQD.

Long-Term Care Services Report

RFP Requirements:	***Section 51.340.1***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March and April through June***
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:	***LTC_0910, LTC_1001, LTC_1004, LTC_1007***

Required Report Information:

The health plan shall submit *Long-Term Care Services Reports* that include the following data from the previous quarter:

- The number and percentage of members (all members and those who meet NF LOC) who transfer from community settings to nursing facilities;
- The number and percentage of members (all members and those who meet NF LOC) who transfer from nursing facilities to community settings;
- The number and days of acute care hospital admissions (all members including those meeting NF LOC);
- The number and percentage of members (all members including those who meet NF LOC) who access ER services;
- The number and percentage of members (all members including those who meet NF LOC) receiving HCBS; and
- The number and percentage of members (all members including those who meet NF LOC) placed in an institutional setting.

Member Grievance and Appeals Report

RFP Requirements:	***Section 51.350.4***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March and April through June***
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_0910, MGA_1001, MGA_1004, MGA_1007***

Required Report Information:

The following is guidance on assembling the quarterly log of member grievances:

- Inquiries need not be reported;
- Report overturn rates, percentages of grievances and appeals that did not meet timeliness requirements;
- Ratios of grievances and appeals per 100 members must also be reported with the quarterly report;
- The plan may be asked to provide additional information for certain cases; and
- All plans must provide member complaints, grievances, and appeals reports in the required Med-QUEST format for all reporting quarters, even when no complaints, grievances, or appeals are logged.

PCP Report

RFP Requirements:	***Section 51.320.3***
Report Scope:	***Monthly, reporting all activities during the report month***
Report Period(s):	***Twelve (12) one-month periods starting July of this year and ending with June of next year***
Report Due Date(s):	***The 15th of each month***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***PCP_(YY,MM) Ex: PCP_0907***

Required Report Information:

The health plan shall submit *PCP Reports* that provide the following information on activities from the previous month:

- The names of newly enrolled members and the name of the PCP to which they are assigned or selected;
- The PCP to member ratio per 1,000 members;
- The percent of PCP panel slots open;
- The number of PCP visits per 1,000 members;
- The percent of new members who did not select a PCP and were assigned to one; and
- The number of PCP change requests received and processes.

Personal Assistance Service Level 1 Report

RFP Requirements:	***Section 51.340.2***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March and April through June***
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:	***PAS_0907, PAS_0910, PAS_1001, PAS_1004, PAS_1007***

Required Report Information:

The health plan shall submit to the DHS on a quarterly basis *The Personal Assistance Services Level 1 Report* that include the following information:

- The names of members on the waiting list;
- The date the member's name was placed on the waiting list;
- Progress notes on the status of providing needed care to the member;
- Names of members assessed to need Personal Assistance Services Level 1 since previous quarter; and
- Names of members assessed to need Personal Assistance Services Level 1 since previous quarter who are receiving the services.

PIP Evaluation

RFP Requirements:	***Section 51.360.5***
Report Scope:	***Annually, reporting all activities during the report year***
Report Period(s):	***One (1) twelve month period, from January through December***
Report Due Date(s):	***April 1***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***PIPE_0912***

Required Report Information:

The health plan shall provide a *PIP Evaluation* of the activities during the previous calendar year that includes, at a minimum:

- Summary of each PIP completed the previous year;
- Analysis of strengths and areas of improvement of each PIP;
- Discussion of incorporation of strengths in health plan practices; and
- Corrective action for each area of improvement.

Prior Authorization Request Denied/ Deferred Report

RFP Requirements:	***Section 51.370.1***
Report Scope:	***Semi-annually, reporting all activities during the report period***
Report Period(s):	***Two (2) six-month periods from July 1 through December 31 and January 1 through June 30***
Report Due Date(s):	***The first day of the third month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***PAR_0909, PAR_1003***

Required Report Information:

The health plan shall submit *Prior Authorization Requests that have been Denied or Deferred Reports*. The specific reporting period, types of services and due dates will be designed by the DHS. The report shall include the following data:

- Date of 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 for the service/ medication;
- Justification of the health plan's denial or the reason(s) for deferral of the request; and
- The date and method of notification of the provider and the member of the health plan's determination.

Proposed Performance Measures Description

RFP Requirements:	***Section 51.360.6***
Report Scope:	***Annually, reporting all activities during the report year***
Report Period(s):	***One (1) twelve month period, from July through June***
Report Due Date(s):	***October 1***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***PPM_0906***

Required Report Information:

The health plan shall submit information about the performance measures that it will be conducting during the next year. The health plan shall submit this information to both the DHS and its EQRO.

Proposed PIPs Description

RFP Requirements:	***Section 51.360.4***
Report Scope:	***Annually, reporting all activities during the report year***
Report Period(s):	***One (1) twelve month period, from July through June***
Report Due Date(s):	***October 1***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***PIPD_0906***

Required Report Information:

The health plan shall submit, on the DHS designated reporting form, information about the PIPs it will be conducting during the next year. The health plan shall submit this information to both the DHS and its EQRO.

Provider Complaints Report

RFP Requirements:	***Section 51.330.1***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March and April through June***
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:	***PCR_0910, PCR_1001, PCR_1004, PCR_1007***

Required Report Information:

The health plan shall submit to the DHS *Provider Complaints Reports* that include the following information from the previous quarter:

- The total number of resolved complaints by category (benefits and limits; eligibility and enrollment; member issues; health plan issues);
- The total number of unresolved complaints by category (benefits and limits; eligibility and enrollment; member issues; health plan issues) and the reason code explaining the status (e.g., complaint is expected to be resolved by the reporting date and complaint is unlikely to be resolved by the reporting date);
- Status of provider complaints 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 14, 30, 60, and 90 days after date of service 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) submitted past the filing deadline for each month in the reporting quarter; (3) provider not eligible on the date of service for each month in the reporting quarter; (4) member not eligible on the date of service; and (5) member has another health insurer which should be billed first.

Provider Network Development and Management Plan

RFP Requirements:	***Section 51.320.1***
Report Scope:	***Annually, reporting all activities during the report year***
Report Period(s):	***One (1) twelve month period, from January through December***
Report Due Date(s):	***July 1, following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***PND_0912, PND_1012***

The health plan shall submit *Provider Network Development and Management Plans* that provide the information detailed in Section 40.210.

Required Report Information:

- Identify the current status of the network at all levels (acute, institutional, HCBS, non-emergency transportation, etc.);
- Project future needs based upon, at a minimum, the anticipated enrollment including expected growth;
- Project the expected utilization of services, taking into consideration the characteristics and health needs of specific populations in the health plan;
- Project the number and types (in terms of training, experience and specialization) of providers required to furnish the contracted services;
- 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 the members, and whether the location provides physical access for members with disabilities;
- Include a component regarding paraprofessional workforce development (as defined in Section 30.200) in nursing facilities, alternative residential facilities and in-home settings (attendant care, personal care and homemaker);

- Specifically, include the following:
  - Evaluation of prior year's plan;
  - Current status of the network, including (1) how members access the system, and (2) relationships between the various levels;
  - Current network gaps and the methodology used to identify them;
  - Immediate short-term interventions when a gap occurs including expedited or temporary credentialing;
  - Interventions to fill network gaps and barriers to those interventions;
  - Outcome measures/evaluations of interventions;
  - Ongoing activities for network development, including (1) current unmet needs, and (2) future needs relating to membership growth;
  - Coordination between the health plan departments and outside organizations;
  - A description of the network for special populations including but not limited to behavioral health and young adults and children including (1) current unmet needs, and (2) future needs relating to membership growth;
  - A description of the adequacy of the geographic access to tertiary hospital services;
  - The methodology(ies) the health plan uses to collect and analyze provider feedback about the network designs and implementation and when specific provider issues are identified, the protocols for handling them; and
  - The strategies the health plan has for workforce development.
- Include the answers to the following questions:
  - Does the health plan utilize any of the following strategies to reduce unnecessary emergency department utilization by its membership? If so, how are members educated about these options: (1) physical coverage/call availability after-hours and on weekends, (2) same day PCP appointments, (3) nurse call-in centers/information lines, (4) urgent care facilities;

- What are the most significant barriers to efficient network development within the health plan's service areas? How can the DHS best support the health plan's efforts to improve its network and the quality of care delivered to its membership?; and

- What types of members are assigned to specialists for their PCPs?

Provider Suspension and Terminations Report

RFP Requirements:	***Section 51.320.6***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March and April through June***
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:	***PST_0910, PST_1001, PST_1004, PST_1007***

The health plan shall submit *Provider Suspension and Terminations Reports* that list by name all provider suspensions or terminations.

Required Report Information:

- All providers (physicians, non-physicians, facilities, agencies, suppliers, etc.);
- Each provider's specialty;
- Their primary city and island of services;
- Reason(s) for the action taken; and,
- The effective date of the suspension or termination.

If the health plan has taken no action against providers during the quarter this should be documented in the *Provider Suspension and Terminations Report.*

QAPI Program Description

RFP Requirements:	***Section 51.360.2***
Report Scope:	***Annually, reporting all activities during the report year***
Report Period(s):	***One (1) twelve month period, from July through June***
Report Due Date(s):	***October 1***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***QPD_0906***

Required Report Information:

The health plan shall provide a *QAPI Program Description.* The health plan's medical director shall review this description prior to submittal to the DHS. The QAPI Program Description 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;
- 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 and utilization management program evaluation reports; and
- Written notification of any delegation of QAPI Program activities to subcontractors.

QAPI Program Evaluation

RFP Requirements:	***Section 51.360.3***
Report Scope:	***Annually, reporting all activities during the report year***
Report Period(s):	***One (1) twelve month period, from January through December***
Report Due Date(s):	***April 1***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***QPE_0912***

Required Report Information:

The health plan shall provide a *QAPI Program Evaluation* of the activities during the previous calendar year that includes, at a minimum:

- Summary of QAPI completed the previous year;
- Analysis of strengths and areas of improvement of the QAPI;
- Discussion of incorporation of strengths in health plan practices; and
- Corrective action for each area of improvement.

QExA Dashboard

RFP Requirements:	***Section 51.380.8***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Twelve (12) one-month periods starting July of this year and ending with June of next year***
Report Due Date(s):	***The 15th of each month***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***QDB_(YY,MM) Ex: QDB_0907***

Required Report Information:

The health plan shall submit a monthly summary identified as the QExA dashboard of QExA health plan performance utilizing a format provided by the DHS. Information included on the QExA 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.

QExA Financial Reporting Guide

RFP Requirements:	***Section 51.380.2***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March and April through June*** ***One (1) twelve month period from July through June***
Report Due Date(s):	***Forty-five (45) days after period end*** ***Annually, the last day of the second month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***FRG_0910, FRG_1001, FRG_1004, FRG_1007***

Required Report Information:

The health plan shall submit financial information on a regular basis in accordance with the *QExA Financial Reporting Guide* to be provided by the DHS. For reference, the QExA Financial Reporting Guide is available in the document library located at www.med-quest.us.

The financial information shall be analyzed and compared to industry standards and standards established by the DHS to ensure the financial solvency of the health plan. The DHS may also monitor the financial performance of the health plan with on-site inspections and audits.

The health plan shall, in accordance with the generally accepted accounting practices, prepare financial reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the health plan's performance of services under this contract.

Report of Over- and Under Utilization of Drugs

RFP Requirements:	***Section 51.370.2***
Report Scope:	***Semi-annually, reporting all activities during the report period***
Report Period(s):	***Two (2) six-month periods from July 1 through December 31 and January 1 through June 30***
Report Due Date(s):	***The first day of the third month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***OUD_0909, OUD_1003***

Required Report Information:

The health plan shall submit *Reports of Over-and Under Utilization of Drugs* that include:

- A - Listing of the top fifty (50) high cost drugs and the top fifty (50) highly utilized drugs, the criteria that that is used/ developed to evaluate their appropriate, safe and effective use, and the outcomes/ results of the evaluations;

- B - Listing the top (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 those medications and the outcomes/ results of the evaluations;

- C - Listing of members who are high users of controlled substances but have no medical conditions (i.e., malignancies, acute injuries, etc.) which would justify the high usage. Additionally, the health plan shall submit: (1) its procedures for referring for the monitoring and controlling their over-utilization; and (2) the result of the CC/CM services provided; and

- D - Result of pharmacy audits, including who performed the audits, what areas were audited, and if problems were found, the action(s) taken to address the issues(s), and outcome of the corrective action(s).

Report of Over-and Under Utilization of Services

RFP Requirements:	***Section 51.370.3***
Report Scope:	***Semi-annually, reporting all activities during the report period***
Report Period(s):	***Two (2) six-month periods from July 1 through December 31 and January 1 through June 30***
Report Due Date(s):	***The first day of the third month following the report period end***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***OUS_0909, OUS_1003***

The health plan shall submit *Reports of Over-and Under Utilization of Services*. These reports shall use data from the following two (2) periods: July 1 - December 31 and January 1 - June 30. The reports shall include information on the following six (6) measures.

Required Report Information:

- A - PCP Visit Rates: The percent of PCPs that are at the top three percent (3%) and bottom three percent (3%) in utilization compared to the health plan's specialty. The health plan shall include only those PCPs that have at least one hundred (100) members assigned to them;

- B - Approved Authorization/ 1000 Member Months: Percent of PCPs that are at the top three percent (3%) and the bottom three percent (3%) in utilization compared to the health plan's specialty norm. The health plan shall include only those PCPs that have at least one hundred (100) members assigned to them;

- C - QI Investigation for Delay in Treatment: The measure to be reported is the rate (twenty percent (20%) or more of QI investigations conducted by the health plan in a 12 month period relating to a delay in treatment by a PCP with more than 100 members;

- D - The over-utilization measure to be reported is the percent of hospitals and other providers delegated to perform concurrent reviews that have one hundred fifty percent (150%) or higher of service utilization exceeding the health plan average. The under-utilization measures shall reflect the percent of hospitals and other providers delegated to perform concurrent reviews that have utilization of twenty-five percent (25%) or less of the recommended services in the clinical decision criteria adopted by the health plan (e.g., Milliman or InterQual guidelines);

- E - Selected Specialty Visit Rates: The percent of individual providers within the specialties of cardiology, general surgery and orthopedics with fifty (50) or more approved prior authorization in a six (6) month period that are at the top and bottom three percent (3%) in utilization compared to the health plan's specialty norm; and

- F - Selected Chronic Conditions: The follow-up utilization variance per clinical practice guidelines or disease management guidelines adopted by the health plan for two (2) relevant chronic conditions selected by the health plan.

For each measure, the health plan shall identify the threshold designated by the health plan's Medical Director that triggers further investigation for over-and/ or under-utilization.

Request for Alternate Language Report

RFP Requirements:	***Section 51.350.3***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March and April through June***
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:	***RAL_0910, RAL_1001, RAL_1004, RAL_1007***

Required Report Information:

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

- The name and member 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.

Service Coordinator Report

RFP Requirements:	***Section 51.340.4***
Report Scope:	***Monthly, reporting all activities during the report month***
Report Period(s):	***Twelve (12) one-month periods starting July of this year and ending with June of next year***
Report Due Date(s):	***The 15th of each month***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***SCR_(YY,MM) Ex: SCR_0907***

Required Report Information:

The health plan shall submit *Service Coordinator Reports* that, using data from the previous month, provide information on:

- The number and percent of new members (those enrolled during the last thirty (30) days) who met with their service coordinator;
- The number and percent of new members who received a HFA;
- The number and percent of new members who had a care plan developed; and
- The number of all members who requested a change in service coordinators.

Timely Access Report

RFP Requirements:	***Section 51.320.4***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March and April through June***
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_0910, TAR_1001, TAR_1004, TAR_1007***

The health plan shall submit *Timely Access Reports* that monitor the time lapse between a member's initial request for an appointment and the date of the appointment.

Required Report Information:

The health plan shall submit a quarterly *Timely Access Report* that monitors the time lapsed between a member's initial request for an office appointment and the date of the appointment. The data for the Timely Access Reports may be collected using statistical sampling methods (including periodic member or provider surveys). The report shall include:

- Total number of appointment requests;
- Total number of requests that meet the waiting time standards (for each provider type/class);
- Total number of requests that exceed the waiting standards (for each provider type/class); and
- Average waiting time for those requests that exceed the waiting time standards (for each provider type/class).

TPL Cost Avoidance Report

RFP Requirements:	***Section 51.380.3***
Report Scope:	***Monthly, reporting all activities during the report month***
Report Period(s):	***Twelve (12) one-month periods starting July of this year and ending with June of next year***
Report Due Date(s):	***The 15th of each month***
Report Formats:	***Electronic copy in a format described by the MQD***
Code:	***TPL_(YY,MM) Ex: TPL_0907***

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.

The plan shall use the format below to report TPL cost-avoided amounts, collections, and accident liability recoveries:

QExA HEALTH PLAN

MONTHLY TPL RECOVERY REPORT

For the Month of _____

Name of Health Plan: _____

1. Health Insurance Plans (COB) Collections:

a)	**Collections .....**		**$ XXXX.XX**
b)	**Cost Avoided Amount .....**		**XXXX.XX**
		Sub Total	**$ XXXX.XX**

2. Accident Liability Recoveries ..... $ XXXX.XX

GRAND TOTAL $ XXXX.XX

Translation/ Interpretation Service Report

RFP Requirements:	***Section 51.350.2***
Report Scope:	***Quarterly, reporting all activities during the report quarter***
Report Period(s):	***Four (4) three-month periods, from July through September, October through December, January through March and April through June***
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:	***TIS_0910, TIS_1001, TIS_1004, TIS_1007***

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 member identification number for each member to whom translation/ interpretation service was provided;
- The date of the request;
- The date provided;
- The type of service including the language requested; and
- The identification of the translator/ interpreter or translator/ interpreter agency.

Summary of EQRO Activities for SFY 2010:

- Validation of HEDIS measures
- Validate 2 PIPs
- Monitor QAPI standards through compliance review
- Conduct CAHPS Adult Medicaid 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 plans will receive notification 60 days prior to the review. These reviews may generate an on-site visit to the plan.

Attachment

c: Dr. Anthea Wang
Chris Butt
Garrett Alcott
Lydia Hemmings
Patti Bazin

QExA PLANS
MONITORING CALENDAR REPORT DUE DATES
ACTIVITY IN JULY 2009– AUGUST 2010

July 2009	August 2009	September 2009	October 2009	November 2009	December 2009	January 2010
TPL Cost Avoidance Report **Report Period:** June 2009 **Due:** July 15	*TPL Cost Avoidance Report* **Report Period:** July 2009 **Due:** August 15	*TPL Cost Avoidance Report* **Report Period:** August 2009 **Due:** September 15	*TPL Cost Avoidance Report* **Report Period:** September 2009 **Due:** October 15	*TPL Cost Avoidance Report* **Report Period:** October 2009 **Due:** November 15	*TPL Cost Avoidance Report* **Report Period:** November 2009 **Due:** December 15	*TPL Cost Avoidance Report* **Report Period:** December 2009 **Due:** January 15
Provider Network Development and Management Plan **Report Period:** January 2008 - December 2008 **Due:** July 1	*CMS 416 Report-EPSDT* **Report Period:** January 2009 - June 2009 **Due:** August 1	*Prior Authorization Request Denied/ Deferred Report* **Report Period:** January 2009 - June 2009 **Due:** September 1	*GeoAccess or Similar Report* **Report Period:** July 2009 - September 2009 **Due:** October 31	*PCP Report* **Report Period:** October 2009 **Due:** November 15	*PCP Report* **Report Period:** November 2009 **Due:** December 15	*GeoAccess or Similar Report* **Report Period:** October 2009 - December 2009 **Due:** January 31
PCP Report **Report Period:** June 2009 **Due:** July 15	*PCP Report* **Report Period:** July 2009 **Due:** August 15	*Report of Over- and Under Utilization of Drugs* **Report Period:** January 2009 - June 2009 **Due:** September 1	*Timely Access Report* **Report Period:** July 2009 - September 2009 **Due:** October 31	*Service Coordinator Report* **Report Period:** October 2009 **Due:** November 15	*Service Coordinator Report* **Report Period:** November 2009 **Due:** December 15	*Timely Access Report* **Report Period:** October 2009 - December 2009 **Due:** January 31
Service Coordinator Report **Report Period:** June 2009 **Due:** July 15	*Service Coordinator Report* **Report Period:** July 2009 **Due:** August 15	*Report of Over- and Under Utilization of Services* **Report Period:** January 2009 - June 2009 **Due:** September 1	*Provider Suspension and Terminations Report* **Report Period:** July 2009 - September 2009 **Due:** October 31	*Call Center Report* **Report Period:** October 2009 **Due:** November 15	*Call Center Report* **Report Period:** November 2009 **Due:** December 15	*Provider Suspension and Terminations Report* **Report Period:** October 2009 - December 2009 **Due:** January 31
Call Center Report **Report Period:** June 2009 **Due:** July 15	*Call Center Report* **Report Period:** July 2009 **Due:** August 15	*PCP Report* **Report Period:** August 2009 **Due:** September 15	*Provider Complaints Report* **Report Period:** July 2009 - September 2009 **Due:** October 31	*QExA Dashboard* **Report Period:** October 2009 **Due:** November 15	*QExA Dashboard* **Report Period:** November 2009 **Due:** December 15	*Provider Complaints Report* **Report Period:** October 2009 - December 2009 **Due:** January 31
QExA Dashboard **Report Period:** June 2009 **Due:** July 15	*QExA Dashboard* **Report Period:** July 2009 **Due:** August 15	*Service Coordinator Report* **Report Period:** August 2009 Due: September 15	Long-Term Care Services Report **Report Period:** July 2009 - September 2009 **Due:** October 31	*QExA Financial Reporting Guide* **Report Period:** July 2009 - September 2009 **Due:** November 15	***Encounter Data/ Financial Summary Reconciliation Report*** **Report Period:** July 2009 - September 2009 **Due:** December 31	Long-Term Care Services Report **Report Period:** October 2009 - December 2009 **Due:** January 31
GeoAccess or Similar Report **Report Period:** April 2009 - June 2009 **Due:** July 31	*Disclosure of Annual Business Transactions* **Report Period:** July 2008 - June 2009 **Due:** Aug 31	*Call Center Report* **Report Period:** August 2009 **Due**: September 15	*Personal Assistance Service Level 1 Report* **Report Period:** July 2009 - September 2009 **Due:** October 31			*Personal Assistance Service Level 1 Report* **Report Period:** October 2009 - December 2009 **Due:** January 31
Timely Access Report **Report Period:** April 2009 - June 2009 **Due:** July 31	*QExA Financial Reporting Guide* **Report Period:** Jul 2008 - June 2009 **Due:** Aug 31, 2009	*QExA Dashboard* **Report Period:** August 2009 **Due:** September 15	*HCBS Report* **Report Period:** July 2009 - September 2009 **Due:** October 31			*HCBS Report* **Report Period:** October 2009 - December 2009 **Due:** January 31
Provider Suspension and Terminations Report **Report Period:** April 2009 - June 2009 **Due:** July 31	*QExA Financial Reporting Guide* **Report Period:** April 2009 - June 2009 **Due:** Aug 15, 2009	***Encounter Data/ Financial Summary Reconciliation Report*** **Report Period:** April 2009 - June 2009 **Due:** September 30	*Translation/ Interpretation Services Report* **Report Period:** July 2009 - September 2009 **Due:** October 31			

...continue July 2009

Provider Complaints Report
Report Period:
April 2009 - June 2009
Due: July 31

Long-Term Care Services Report
Report Period:
April 2009 - June 2009
Due: July 31

Personal Assistance Service Level 1 Report
Report Period:
April 2009 - June 2009
Due: July 31

HCBS Report
Report Period:
April 2009 - June 2009
Due: July 31

Translation/ Interpretation Services Report
Report Period:
April 2009 - June 2009
Due: July 31

Request for Alternate Language Report
Report Period:
April 2009 - June 2009
Due: July 31

Member Grievances and Appeals Report
Report Period:
April 2009 - June 2009
Due: July 31

Accreditation Update
Report Period:
April 2009 - June 2009
Due: July 31

Fraud and Abuse Summary Report
Report Period:
April 2009 - June 2009
Due: July 31

Services Rendered to Member by an FQHC or RHC
Report Period:
April 2009 - June 2009
Due: July 31

...continue October 2009

Request for Alternate Language Report
Report Period:
July 2009 - September 2009
Due: October 31

Member Grievances and Appeals Report
Report Period:
July 2009 - September 2009
Due: October 31

Accreditation Update
Report Period:
July 2009 - September 2009
Due: October 31

Fraud and Abuse Summary Report
Report Period:
July 2009 - September 2009
Due: October 31

Services Rendered to Member by an FQHC or RHC
Report Period:
July 2009 - September 2009
Due: October 31

QAPI Program Description
Report Period:
July 2008 - June 2009
Due: October 1

Proposed PIPs Description
Report Period:
July 2008 - June 2009
Due: October 1

Proposed Performance Measures Description
Report Period:
July 2008 - June 2009
Due: October 1

PCP Report
Report Period:
September 2009
Due: October 15

Service Coordinator Report
Report Period:
September 2009
Due: October 15

...continue January 2010

Translation/ Interpretation Services Report
Report Period:
October 2009 - December 2009
Due: January 31

Request for Alternate Language Report
Report Period:
October 2009 - December 2009
Due: January 31

Member Grievances and Appeals Report
Report Period:
October 2009 - December 2009
Due: January 31

Accreditation Update
Report Period:
October 2009 - December 2009
Due: January 31

Fraud and Abuse Summary Report
Report Period:
October 2009 - December 2009
Due: January 31

Services Rendered to Member by an FQHC or RHC
Report Period:
October 2009 - December 2009
Due: January 31

PCP Report
Report Period:
December 2009
Due: January 15

Service Coordinator Report
Report Period:
December 2009
Due: January 15

Call Center Report
Report Period:
December 2009
Due: January 15

			...continue October 2009 *Call Center Report* **Report Period:** September 2009 **Due:** October 15 *QExA Dashboard* **Report Period:** September 2009 **Due:** October 15			*...continue January 2010* *QExA Dashboard* **Report Period:** December 2009 **Due:** January 15

QExA PLANS
MONITORING CALENDAR REPORT DUE DATES
ACTIVITY IN JULY 2009– JUNE 2010

February 2010	March 2010	April 2010	May 2010	June 2010	July 2010	August 2010
TPL Cost Avoidance Report **Report Period:** January 2010 **Due:** February 15	*TPL Cost Avoidance Report* **Report Period:** February 2010 **Due:** March 15	*TPL Cost Avoidance Report* **Report Period:** March 2010 **Due:** April 15	*TPL Cost Avoidance Report* **Report Period:** April 2010 **Due:** May 15	*TPL Cost Avoidance Report* **Report Period:** May 2010 **Due:** June 15	*TPL Cost Avoidance Report* **Report Period:** June 2010 **Due:** July 15	*TPL Cost Avoidance Report* **Report Period:** July 2010 **Due:** August 15
CMS 416 Report- EPSDT **Report Period:** July 2009 - December 2009 **Due:** February 1	*Prior Authorization Request Denied/ Deferred Report* **Report Period:** July 2009 - December 2009 **Due:** March 1	*GeoAccess or Similar Report* **Report Period:** January 2010 - March 2010 **Due:** April 30	*(Annual) Service Rendered to Member by an FQHC or RHC Report* **Report Period:** Jan 2009 - Dec 2010 **Due:** May 31	*Health Plan Employer Data and Information Set (HEDIS) Report* **Report Period:** January 2009 - December 2009 **Due:** June 15	*Provider Network Development and Management Plan* **Report Period:** January 2009 - December 2009 **Due:** July 1	*CMS 416 Report- EPSDT* **Report Period:** January 2010 - June 2010 **Due:** August 1
PCP Report **Report Period:** January 2010 **Due:** February 15	*Report of Over- and Under Utilization of Drugs* **Report Period:** July 2009 - December 2009 **Due:** March 1	*Timely Access Report* **Report Period:** January 2010 - March 2010 **Due:** April 30	*PCP Report* **Report Period:** April 2010 **Due:** May 15	*PCP Report* **Report Period:** May 2010 **Due:** June 15	*PCP Report* **Report Period:** June 2010 **Due:** July 15	*PCP Report* **Report Period:** July 2010 **Due:** August 15
Service Coordinator Report **Report Period:** January 2010 **Due:** February 15	*Report of Over- and Under Utilization of Services* **Report Period:** July 2009 - December 2009 **Due:** March 1	*Provider Suspension and Terminations Report* **Report Period:** January 2010 - March 2010 **Due:** April 30	*Service Coordinator Report* **Report Period:** April 2010 **Due:** May 15	*Service Coordinator Report* **Report Period:** May 2010 **Due:** June 15	*Service Coordinator Report* **Report Period:** June 2010 **Due:** July 15	*Service Coordinator Report* **Report Period:** July 2010 **Due:** August 15
Call Center Report **Report Period:** January 2010 **Due:** February 15	*PCP Report* **Report Period:** February 2010 **Due:** March 15	*Provider Complaints Report* **Report Period:** January 2010 - March 2010 **Due:** April 30	*Call Center Report* **Report Period:** April 2010 **Due:** May 15	*Call Center Report* **Report Period:** May 2010 **Due:** June 15	*Call Center Report* **Report Period:** June 2010 **Due:** July 15	*Call Center Report* **Report Period:** July 2010 **Due:** August 15
QExA Dashboard **Report Period:** January 2010 **Due:** February 15	*Service Coordinator Report* **Report Period:** February 2010 **Due:** March 15	Long-Term Care Services Report **Report Period:** January 2010 - March 2010 **Due:** April 30	*QExA Dashboard* **Report Period:** April 2010 **Due:** May 15	*QExA Dashboard* **Report Period:** May 2010 **Due:** June 15	*QExA Dashboard* **Report Period:** June 2010 **Due:** July 15	*QExA Dashboard* **Report Period:** July 2010 **Due:** August 15
QExA Financial Reporting Guide **Report Period:** October 2009 - December 2009 **Due:** February 15	*Call Center Report* **Report Period:** February 2010 **Due:** March 15	*Personal Assistance Service Level 1 Report* **Report Period:** January 2010 - March 2010 **Due:** April 30	*QExA Financial Reporting Guide* **Report Period:** January 2010 - March 2010 **Due:** May 15	***Encounter Data/ Financial Summary Reconciliation Report*** **Report Period:** January 2010 - March 2010 **Due:** June 30	*GeoAccess or Similar Report* **Report Period:** April 2010 - June 2010 **Due:** July 31	*Disclosure of Annual Business Transactions* **Report Period:** July 2009 - June 2010 **Due:** Aug 31
	QExA Dashboard **Report Period:** February 2010 **Due:** March 15	*HCBS Report* **Report Period:** January 2010 - March 2010 **Due:** April 30			*Timely Access Report* **Report Period:** April 2010 - June 2010 **Due:** July 31	*QExA Financial Reporting Guide* **Report Period:** Jul 2009 - June 2010 **Due:** Aug 31, 2009
	Encounter Data/ Financial Summary Reconciliation Report **Report Period:** October 2009 - December 2009 **Due:** March 31	*Translation/ Interpretation Services Report* **Report Period:** January 2010 - March 2010 **Due:** April 30			*Provider Suspension and Terminations Report* **Report Period:** April 2010 - June 2010 **Due:** July 31	*QExA Financial Reporting Guide* **Report Period:** April 2010 - June 2010 **Due:** August 15

		...continue April 2010 *Request for Alternate Language Report* **Report Period:** January 2010 - March 2010 **Due:** April 30 *Member Grievances and Appeals Report* **Report Period:** January 2010 - March 2010 **Due:** April 30 *Accreditation Update* **Report Period:** January 2010 - March 2010 **Due:** April 30 *Fraud and Abuse Summary Report* **Report Period:** January 2010 - March 2010 **Due:** April 30 *Services Rendered to Member by an FQHC or RHC* **Report Period:** January 2010 - March 2010 **Due:** April 30 *PCP Report* **Report Period:** March 2010 **Due:** April 15 *Service Coordinator Report* **Report Period:** March 2010 **Due:** April 15 *Call Center Report* **Report Period:** March 2010 **Due:** April 15 *QExA Dashboard* **Report Period:** March 2010 **Due:** April 15 *QAPI Program Evaluation* **Report Period:** January 2009 - December 2009 **Due:** April 1			*...continue July 2010* *Provider Complaints Report* **Report Period:** April 2010 - June 2010 **Due:** July 31 Long-Term Care Services Report **Report Period:** April 2010 - June 2010 **Due:** July 31 *Personal Assistance Service Level 1 Report* **Report Period:** April 2010 - June 2010 **Due:** July 31 *HCBS Report* **Report Period:** April 2010 - June 2010 **Due:** July 31 *Translation/ Interpretation Services Report* **Report Period:** April 2010 - June 2010 **Due:** July 31 *Request for Alternate Language Report* **Report Period:** April 2010 - June 2010 **Due:** July 31 *Member Grievances and Appeals Report* **Report Period:** April 2010 - June 2010 **Due:** July 31 *Accreditation Update* **Report Period:** April 2010 - June 2010 **Due:** July 31 *Fraud and Abuse Summary Report* **Report Period:** April 2010 - June 2010 **Due:** July 31 *Services Rendered to Member by an FQHC or RHC* **Report Period:** April 2010 - June 2010 **Due:** July 31	

		...continue April 2010 *PIP Evaluation* **Report Period:** January 2009 - December 2009 **Due:** April 1				

HCSB Monitoring Activities that need to be scheduled and may not require additional reporting by the health plans	CSO Monitoring Activity that may be scheduled
• Monitoring claims payment timeliness & payment review policies • Compliance with sterilization/hysterectomy claims payments • Compliance with required language in agreements with subcontractors • Monitoring the plan's contracted provider network • Monitoring of timeliness & accuracy of encounter data submissions • Compliance with HIPAA regulations	• Review of Catastrophic Cases