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**STATE OF HAWAII**
**DEPARTMENT OF HUMAN SERVICES**
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
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March 17, 2010

MEMORANDUM

QUEST MEMO
RPT-0906

TO: QUEST Health Plans

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

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) that began *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 53.010) The Health Plans retain ultimate responsibility for all delegated activities and the results of these activities, where applicable, should be included in the appropriate reports.

The MQD reviews focus primarily on Quality Improvement. Generally, QUEST 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 55.020)

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 70.900)

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 55.020)

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 QUEST 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.

**Aid To Disabled Review Committee (ADRC) Report**

***RFP Requirements:*** **30.780**

***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 & April through June***

***Report Due Date(s):*** ***Last day of the month following the report period end***

***Report Formats:*** ***Electronic file in a format described by MQD***

***Code:*** ***ADR_0909, ADR_0912, ADR_1003, ADR_1006***

The MQD will be more closely monitoring the entire ADRC process, and hopefully, reducing the number of inappropriate ADRC referrals. The quality objective for each health plan is the delay or prevention of permanent disability through intensive, integrative case management and disease management's efforts as required by our current contract.

*Required Report Information:*

- Member name and Medicaid ID#;
- Member's primary diagnosis;
- Total number of ADRC referrals made within reporting period;
- Total number of referrals deemed "disabled";
- Total number of referrals determined "not disabled"; and
- Total number of referrals deemed "not disabled" who were then referred back or intensive case management services.

## CAHPS® Consumer Survey

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.740*** |
| ***Report Scope:*** | ***Monthly*** |
| ***Report Period(s):*** | ***If applicable*** |
| ***Report Due Date(s):*** | ***If applicable*** |
| ***Report Formats:*** | ***Copy of CAHPS survey in both hard and electronic format*** |
| ***Code:*** | ***CAHPS*** |

*Required Report Information:*

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

## Call Center Report

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.710*** |
| ***Report Scope:*** | ***Monthly, reporting all activities during the report month*** |
| ***Report Period(s):*** | ***One month period*** |
| ***Report Due Date(s):*** | ***The 15th of each month starting in March 2010*** |
| ***Report Formats:*** | ***Electronic file in a format described by the MQD*** |
| ***Code:*** | ***CCR_1002, CCR_1003, CCR_1004, CCR_1005, CCR_1006*** |

*Required Report Information:*

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

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

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

**Case Management Report**

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.760*** |
| ***Report Scope:*** | ***Quarterly, reporting all activities during the report quarter*** |
| ***Report Period(s):*** | ***Three (3) three-month periods, from December, January through March & April through June*** |
| ***Report Due Date(s):*** | ***Last day of the second month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by the MQD*** |
| ***Code:*** | ***CMR_0912, CMR_1003, CMR_1006*** |

*Required Report Information:*

Reports shall include a list of all clients who received case management services over the past quarter, their pertinent diagnosis, start and end date of case management services, estimated length of continued services if still occurring and a total of the number of clients who received case management services (excludes disease management services) for the quarter.

## Disclosure of Information on Annual Business Transactions Report

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 52.130*** |
| ***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):*** | ***August 31, 2010*** |
| ***Report Formats:*** | ***Electronic file in a format described by the MQD*** |
| ***Code:*** | ***ABT_1006*** |

*Required Report Information:*

Report must disclose information on the following types of transactions:

- Any sale, exchange, or lease of any property between the health plan and a party in interest (as defined in Section 1318(b) of the Public Health Service Act);
- Any lending of money or other extension of credit between the health plan and a party in interest; and
- Any furnishing for consideration of goods, services (including management services) or facilities between the health plan and the party in interest (does not include salaries paid to employees for services provided in the normal course of their employment).

Health plan shall include the following information in the transactions listed above:

- Name of the party in interest for each transaction;
- Description of each transaction and the quantity or units involved;
- Accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

## Encounter Data Reporting

***RFP Requirements:*** ***52.200***

***Report Scope:*** ***Monthly, reporting all claim activities during the report month***

***Report Period(s):*** ***N/A***

***Report Due Date(s):*** ***The first and/or third Wednesday of each month***

***Report Formats:*** ***Based on Health Plan Encounter Manual***

Health plans are required to submit encounters to the MQD once per month. Plans have the option to submit encounters twice a month. Encounters must be submitted following the guidelines in the Health Plan Encounter Manual. Each encounter submission must be certified and submitted by the health plans as required in 42 CFR §438.606 and as specified in Sections 52.300 and 52.400.

***Reporting Timelines/Sanctions***

- *HP will be notified within 30 days of submission or completion of accuracy edits;*
- *If failed, HP shall be granted a 30-day error resolution period; and*
- *If at the end of 30 days, the HP accuracy and completion edits failure exceeds 15%, a penalty up to 10% of the monthly capitation shall be assessed.*

**Early Periodic Screening, Diagnosis, and Treatment (EPSDT) - Form CMS 416 Report**

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.510*** |
| ***Report Scope:*** | ***Annually, reporting all activities during the report year*** |
| ***Report Period(s):*** | ***One (1) twelve month period for the federal fiscal year, from October 1 through through September 30*** |
| ***Report Due Date(s):*** | ***February 28, 2010*** |
| ***Report Formats:*** | ***Electronic file in a format described by the MQD*** |
| ***Code:*** | ***416_09*** |

Required Report Information:

The health plans have previously been provided with formatting instructions (QUEST Memo RPT-9909). The plans must follow the memorandum instructions in preparing this report. The QUEST plans are required to have these reports reviewed by their Medical Director prior to submittal.

**Federally Qualified Health Centers/Rural Health Centers (FQHC/RHC) Services Rendered Report**

| | |
|---|---|
| *RFP Requirements:* | *RFP Section 51.440* |
| *Report Scope:* | *Annually, reporting all activities during the report year* |
| *Report Period(s):* | *One (1) twelve month period, from January 1 through December 31* |
| *Report Due Date(s):* | *June 30th following the report period end* |
| *Report Formats:* | *Electronic file in a format described by the MQD* |
| *Code:* | *FQH_09* |

*Required Report Information:*

The plan must submit a report of services rendered to members by an FQHC or RHC. The report shall include the following information:

- Total dollar amounts of payments made to an FQHC/RHC listed by FQHC/RHC;
- The report should include all visits and payments, which includes capitation payments, made to any FQHC/RHC, regardless of whether the FQHC/RHC is included in the plan's contracted provider network and shall include the following information in excel format:

  (a) Name of the Beneficiary;

  (b) Date of Service;

  (c) Visit Type;

  (d) Servicing Provider Name;

  (e) Payment Amount;

  (f) Primary Diagnosis (ICD-9); and

  (g) CPT Codes.

- Claims (Encounters) rejected should be reported separately which shall include:

  (a) Name of the Beneficiary;

  (b) Date of Service;

  (c) Visit Type;

  (d) Servicing Provider Name;

(e) Payment Amount;

(f) Primary Diagnosis (ICD-9); and

(g) CPT Codes.

- Number of unduplicated visits provided to the health plan's members;
- The MQD may ask for the number of unduplicated visits provided to the plan's members listed by FQHC/RHC, at a later time; and
- FQHC's may be audited for the following as required by 42 USCS §233 to ensure compliance with Federal Regulations.

  (a) Implemented appropriate policies and procedures to reduce the risk of malpractice and the risk of lawsuits arising out of any health or health-related functions performed by the entity; and

  (b) Reviewed and verified the professional credentials, references, claims history, fitness, professional review organization findings, and license status of its physicians and other licensed or certified health care practitioners, and, where necessary, has obtained the permission from these individuals to gain access to this 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.<br><br>Submit one report to include all providers of this type.<br><br>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.<br><br>**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.<br><br>The MCO should submit the data file for all FQHC/RHC providers as follows:<br><br>Accumulate all data based on date of service.<br><br>**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.<br>Note: The sum of FFS payments (Data Element 13 and 14) must equal the respective detail claims/encounter data file.<br><br>**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.<br><br>All performance incentives (excluding dollars paid as capitation or fee-for-service reimbursement) which accrued or was paid during the reporting period.<br>Total capitation payments made to the provider for the reporting period.<br>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).<br><br>Submit one report per provider<br><br>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.<br><br>**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.<br><br>The MCO should submit the data file for all FQHC/RHC providers as follows:<br><br>**Include the line level detail of all claims in which Medicaid is the primary payer.**<br><br>**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.<br><br>**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. |

June 25, 2009

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).<br><br>Submit one report per provider<br><br>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.<br><br>**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.<br><br>The MCO should submit the data file for all FQHC/RHC providers as follows:<br><br>**Include the line level detail of all claims in which Medicaid is the secondary payer.**<br><br>**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.<br><br>**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) |

**Fraud and Abuse Report**

***RFP Requirements:*** ***RFP Section 51.900***

***Report Scope:*** ***Various, reporting all activities uncovered***

***Report Period(s):*** ***Various***

***Report Due Date(s):*** ***Thirty (30) days after discovery***

***Report Formats:*** ***Electronic file in a format described by MQD***

All incidences of suspected fraud and abuse identified at the health plan level must be reported to the MQD. The required format for reporting is found in Appendix X in the current contract.

*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.

**HealthCare Effectiveness Data and Information Set (HEDIS) Report to be issued under separate cover letter when new measures are distributed.**

| | |
|---|---|
| ***RFP Requirements:*** | **51.620** |
| ***Report Scope:*** | ***Annually, reporting all activities during the report period*** |
| ***Report Period(s):*** | ***One (1) twelve month period, from January through December*** |
| ***Report Due Date(s):*** | ***June 15, 2010*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***HED_09*** |

*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 QUEST HEDIS reports.

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

The HEDIS report covering the Calendar Year 2009 period January 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 population 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.

**Medicaid Contracting Report**

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 52.150*** |
| ***Report Scope:*** | ***Annually, reporting all activities during the report year*** |
| ***Report Period(s):*** | ***Health Plan financial year*** |
| ***Report Due Date(s):*** | ***December 31, 2009*** |
| ***Report Formats:*** | ***Electronic file in an Excel*** |
| ***Code:*** | ***MCR_0912*** |

*Required Report Information:*

The health plan shall submit an annual Medicaid contracting report to DHS, the State of Hawaii Department of Commerce and Consumer Affairs Insurance Division, and the Hawaii State Legislature, no later than one-hundred eighty (180) days following the end of the State Fiscal Year (SFY) or December 31. The content of the Medicaid contracting report will include the information required by Act 12, First Special Session 2009. The health plan shall submit the report using the format provided by the DHS.

## Member Grievances & Appeals Reports

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.750*** |
| ***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 & April through June*** |
| ***Report Due Date(s):*** | ***Last day of the second month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in an Excel file and spreadsheet format*** |
| ***Code:*** | ***MGA_0909, MGA_0912, MGA_1003, MGA_1006*** |

*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 1,000 members must also be reported with the quarterly report.
- The plan may be asked to provide additional information for certain cases.
- 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 Assignment Report

| | |
|---|---|
| *RFP Requirements:* | ***RFP Section 51.420*** |
| *Report Scope:* | ***Quarterly, reporting status at the end of 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 month following the report period end*** |
| *Report Formats:* | ***Electronic file in a format described by MQD*** |
| *Code:* | ***PCP_0909, PCP_0912, PCP_1003, PCP_1006*** |

Each health plan shall submit on a quarterly basis each member's name and PCP to which each member is assigned. If the PCP is a clinic, then the health plan can look-up the clinic's Medicaid ID# in the Provider Master Registry (PMR). If the clinic does not have a current Medicaid ID#, then the plan can submit a Health Plan Add (HPA) File to the MQD requesting a Medicaid ID# for the clinic.

*Required Report Information:*

- Member's Medicaid ID#
- Member's Name
- PCP's Medicaid ID#
- PCP's Name
- Health Plan ID#

## Performance Improvement Project (PIP) Documentation Report

***RFP Requirements:*** ***RFP Section 51.630***

***Report Scope:*** ***Annual***

***Report Period(s):*** ***N/A***

***Report Due Date(s):*** ***March 31, 2010 (on-going PIPs)***

***Report Formats:*** ***E-file submitted to HSAG and MQD/ FTP sites***

*Required Report Information:*

Each health plan shall complete PIPs which must meet requirements as stated in the CMS Protocol: *Validating Performance Improvement Projects, A Protocol for Use in Conducting External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002.* Each PIP must specifically and exclusively target improvement in relevant areas of clinical care and non-clinical services impacting the health, functional status and/or satisfaction of a significant portion of the plan's QUEST membership (or a specified sub-portion of members). PIPs that do not include a known number of QUEST members will not be accepted. Example: If a PIP covers two years – at least one year must include 2009 and the data must be reported by the applicable year separate from the previous year.

**For 2009-2010 MQD will require 3 PIPS for each of the QUEST health plan:**

1. **Continuation of the on-going PIP for Access to Care**
   - Submission date of this PIP will be March 22, 2010.

2. **Continuation of the on-going PIP for Obesity**
   2009-2010- With the Baseline year of October 1, 2008 through September 30, 2009, MQD staff and HSAG expects to see Activities I through VIII completed. The plan should report and analyze Baseline data. A causal/barrier analysis should be completed and discussed, as well as intervention strategies planned and implemented.
   - Submission date of this PIP will be March 22, 2010.

3. **A new PIP to improve a HEDIS Clinical Performance Measure**
   Additionally, each health plan should select a new study topic where opportunities for improvement have been identified based on past performance rates on one of the HEDIS clinical performance measures. It is expected that the plan completes Steps I through VIII, using the 2009 HEDIS result as the baseline.
   - Submission date of this PIP will be March 31, 2010.

HSAG will continue to offer teleconference to QUEST health plans, if needed during April 26, 2010 through April 30, 2010 and as directed by the MQD.

## Prior Authorization Requests that have been Denied or Deferred Report

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.810*** |
| ***Report Scope:*** | ***Semi-annually, reporting all activities during the report period*** |
| ***Report Period(s):*** | ***Two (2) six-month periods from July 1 through December 30, and January 1 through June 30*** |
| ***Report Due Date(s):*** | ***Last day of the month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***PAR_0912, PAR_1006*** |

Health plans are required to correctly interpret the QUEST program's benefits and appropriately apply the program's medical necessity criteria to all services requested.

*Required Report Information:*

- Date of the request;
- Name of the requesting provider;
- Member's name and ID number;
- Date of Birth;
- Diagnoses and service/medication being requested;
- Justification given by the provider for the member's need of the service/medication;
- Justification of the health plan's denial or the reason(s) for deferral of the request; and
- Date and method of notification of the provider and the member of the health plan's determination.

**Provider Complaints & Claims Report**

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.460*** |
| ***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 & April through June*** |
| ***Report Due Date(s):*** | ***Last day of the second month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by the MQD*** |
| ***Code:*** | ***PCC_0909, PCC_0912, PCC_1003, PCC_1006*** |

*Required Report Information:*

The following is guidance on assembling the quarterly log of provider complaints/claims report:

- A quarterly report which totals the number of complaints by category (benefits and limits; eligibility and enrollment; member issues; health plan issues) which were resolved during the reporting quarter;

- A quarterly report which totals the number of complaints by category (benefits and limits; eligibility and enrollment; member issues; health plan issues) and by unresolved provider complaint reason code (whether a complaint is expected to be resolved or not);

- A quarterly follow-up report consisting of data elements specified by DHS for provider complaints unresolved in previous quarter(s); and

- A quarterly report 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 date of service for each month in the reporting quarter, 4) member not eligible on date of service, and 5) member has another health insurer which should be billed first.

## Provider Network Adequacy and Capacity Report

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.410*** |
| ***Report Scope:*** | ***Quarterly, reporting status at the end of 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 month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***PNA_0909, PNA_0912, PNA_1003, PNA_1006*** |

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

*Required Report Information:*

- Listing of all providers, including specialty or type of practice;
- Provider's location;
- Mailing address including zip code;
- Telephone number;
- Professional license number and expiration date;
- Number of members from its plan currently assigned to provider (PCPs only);
- Whether provider limits number of program patients s/he will accept;
- Whether provider is accepting new patients;
- Languages spoken (if applicable);
- Verification of valid license for in-state and out-of-state providers; and
- Verification that provider or affiliated provider is not on federal or state exclusions list.

**Provider Suspensions & Terminations Report**

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.450*** |
| ***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 & April through June*** |
| ***Report Due Date(s):*** | ***Last day of the second month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***PST_0909, PST_0912, PST_1003, PST_1006*** |

*Required Report Information:*

Please include:

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

If the health plan has not suspended or terminated any provider during these respective periods, please report this in writing. Indicate if the plan reported the suspended and/or termination to the National Practitioner Databank.

**Quality Assurance and Performance Improvement (QAPI) and Staff Changes Report**

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.610*** |
| ***Report Scope:*** | ***Annually*** |
| ***Report Period(s):*** | ***One (1) twelve month period, from January through December*** |
| ***Report Due Date(s):*** | ***March 31, 2010*** |
| ***Report Formats:*** | ***Electronic file appropriately named; hard copy with appropriate tabs*** |
| ***Code:*** | ***QAP_09*** |

*Required Report Information:*

In accordance with 42 C.F.R. 438.240(e), the DHS will review at least the impact and effectiveness of each health plan's QAPI Program. The health plan shall have in place a utilization management program (UMP) that is linked with and supports the health plan's QAPI Program. The UMP description and corresponding workplan may be submitted as separate documents.

- Any changes to QAPI;
- Detailed set of program goals and objectives that are developed annually and include timetables for implementation and accomplishments;
- Copy of the health plan's organizational chart including vacancies of required staff, changes in scope of responsibilities, changes in delegated activities and additions or deletions of positions;
- Current list of the required staff as detailed in Section 51.200 including name, title, location, phone number, and fax number;
- Executive summary outlining changes from the prior QAPI Plan;
- Written notification of any delegation of QAPI activities to contractors;
- 2010 approved and signed Annual QAPI and Work-Plan;
- 2010 Annual Workplan which shall include the PIP-related activities and corresponding benchmarks for the 2010 calendar year; and
- 2009 Annual QAPI Evaluation and if applicable, a separate Annual UM Program Evaluation.
    - HSAG's final 2009 PIP Evaluation Findings and, if applicable, description of the progress to date on the corrective actions completed.

## QUEST Financial Reporting Guide Report

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 52.110*** |
| ***Report Scope:*** | ***Quarterly, reporting all activities during the report quarter***<br>***Annually, reporting all activities during the report year*** |
| ***Report Period(s):*** | ***Four (4) three-month periods, from July through September, October through December, January through March & April through June***<br>***One (1) twelve month period, from January through December*** |
| ***Report Due Date(s):*** | ***Forty-five (45) days after period end***<br>***Annually, the last day of the second month following the report period end*** |
| ***Report Formats:*** | ***Hard copy submitted directly to the Finance Office*** |

*Required Report Information:*

Health Plan must submit financial information directly to the Fiscal Officer on a regular basis in accordance with the QUEST Financial Reporting Guide in Appendix S, and must comply by submitting all quarterly and annual reports and data in the formats prescribed in the QUEST Financial Reporting Guide. DHS can increase frequency of financial reporting. Financial Information shall be analyzed and compared to industry standards and DHS-established standards to ensure health plan's financial solvency. DHS may also monitor financial solvency of health plan with onsite inspections and audits.

- Financial reports must adequately reflect all direct and indirect expenditures and management and fiscal practices related to the health plan's performance of services under new contract.

**Report of Over- and Under-Utilization of Drugs**

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.820*** |
| ***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):*** | ***Last day of the second month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***OUD_0912, OUD_1006*** |

*Required Report Information:*

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

- B – Listings of the top fifty (50) highest utilized non-formulary drugs paid for by the plan including the charges and allowances for each drug as well as the criteria used/developed to evaluate the appropriate, safe and effective use of these medications and the outcomes/results of the evaluations;

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

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

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

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.830*** |
| ***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):*** | ***Last day of the second month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***OUS_0912, OUS_1006*** |

*Required Report Information:*

The following six reports are to be submitted two times per year:

- 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/1,000 Member Months: 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;
- C – QI Investigations for Delay in Treatment: The measure to be reported is the rate (20% or more) of QUI 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 – Not needed this year;
- E – Not needed this year; and
- F – Not needed this year.

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 Documents in Alternate Languages Report**

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.730*** |
| ***Report Scope:*** | ***Quarterly, reporting all activities during the report quarter*** |
| ***Report Period(s):*** | ***Three (3) three-month periods, December, January through March & April through June*** |
| ***Report Due Date(s):*** | ***Last day of the second month after period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***ALR_0912, ALR _1003, ALR_1006*** |

*Required Report Requirements:*

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

- The name and Medicaid identification number for each member requesting documents in an alternative language;
- The language requested;
- The data of the request; and
- The date the documents were mailed or provided.

**Third Party Liability (TPL) Cost Avoidance Report**

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 52.120*** |
| ***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):*** | ***Last day of the month following the end of the reporting period*** |
| ***Report Formats:*** | ***Electronic copy in a format described by the MQD*** |
| ***Code:*** | ***TPL_(YYMM) Ex: TPL_0907*** |

*Required Report Information:*

As stated in QUEST Memo #ADM-9701, the State of Hawaii has placed responsibility for coordination of health care benefits and identification of any third party liabilities (TPLs) for QUEST recipients on the health plans. Information on TPLs is obtained from recipients and is provided to the plans on the monthly enrollment tape. If a plan learns of a TPL, the plan should report the TPL on the Health Plan Change Report Form (DHS #1179). If a recipient has a TPL, the QUEST plan is responsible for notifying the recipient to utilize services covered by the TPL (hereinafter referred to as the primary plan) before accessing QUEST services. QUEST plans shall develop procedures to assist the providers in identifying QUEST enrollees with a TPL.

The QUEST plan is responsible for providing (paying) for all other services including co-payments not covered by the primary plan, but covered under the QUEST program (preventive services, drugs, vision services, transportation, etc.). When services are provided to a QUEST enrollee by the primary plan, the QUEST plan shall obtain the "cost-avoided" amount before providing the co-payment amount to the primary plan. The QUEST plan shall report services provided by the primary plan to QUEST recipients as "cost avoidance" on its monthly TPL report to the State. Services rendered by the QUEST plan that are covered benefits under the primary plan shall be billed to the primary plan. Collections received from the primary plan shall be reported as Health Insurance Plan Collections.

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

***QUEST 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**

**Timely Access Report**

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.430*** |
| ***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 & April through June*** |
| ***Report Due Dates:*** | ***Last day of the second month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***TAR_0909, TAR_0912, TAR_1003, TAR_1006*** |

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

*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).

**Translation/Interpretation Services Report**

| | |
|---|---|
| ***RFP Requirements:*** | ***RFP Section 51.720*** |
| ***Report Scope:*** | ***Quarterly, reporting all activities during the report quarter*** |
| ***Report Period(s):*** | ***Three (3) three-month periods, from December, January through March & April through June*** |
| ***Report Due Dates:*** | ***Last day of the month following the report period end*** |
| ***Report Formats:*** | ***Electronic file in a format described by MQD*** |
| ***Code:*** | ***TIR_0912, TIR_1003, TIR_1006*** |

*Required Report Information:*

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

- The name and Medicaid 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 (HMSA, Kaiser, AlohaCare);
- Monitor QAPI standards through compliance review;
- Conduct CAHPS Adult Medicaid Survey for HMSA, Kaiser, and AlohaCare;
- Provide technical assistance as directed by the MQD, including guidance on PIP activities, compliance, and corrective action plans; and
- Assist with the development of our QUEST Pay for Performance Initiative.

**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: Monitoring Calendar Chart

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

**QUEST MEDICAL PLANS**
**MONITORING CALENDAR REPORT DUE DATES**
**ACTIVITY IN JULY 2009– JUNE 2010**

| July 2009 | August 2009 | September 2009 | October 2009 | November 2009 | December 2009 | January 2010 |
|---|---|---|---|---|---|---|
| *TPL Cost Avoidance*<br>**Report Period:**<br>June 2009<br><br>*Provider Network Adequacy and Capacity*<br>**Report Period:**<br>April 2009 - June 2009<br><br>*PCP Assignment*<br>**Report Period:**<br>April 2009 – June 2009<br><br>*ADRC*<br>**Report Period:**<br>April 2009 – June 2009<br><br>*PA Denial or Deferral*<br>**Report Period:**<br>January 2009 –June 2009 | *TPL Cost Avoidance*<br>**Report Period:**<br>July 2009<br><br>*Grievances & Appeals*<br>**Report Period:**<br>April 2009 – June 2009<br><br>*Provider Complaints & Claims*<br>**Report Period:**<br>April 2009 - June 2009<br><br>*Provider Suspensions & Terminations*<br>**Report Period:**<br>April 2009 - June 2009<br><br>*QUEST Financial Reporting Guide*<br>**Report Period:**<br>April 2009 - June 2009<br>***Due Date: August 15, 2009***<br><br>*Timely Access Report*<br>**Report Period:**<br>April 2009 - June 2009<br><br>*Over/Under Utilization of Drugs*<br>**Report Period:**<br>January 2009 - June 2009<br><br>*Over/Under Utilization of Services*<br>**Report Period:**<br>January 2009 – June 2009<br><br>*Annual Business Transactions*<br>**Report Period:**<br>July 2008 – June 2009 | *TPL Cost Avoidance*<br>**Report Period:**<br>August 2009<br><br>*Encounter Data/Financial Summary Reconciliation*<br>**Report Period:**<br>April 2009 - June 2009 | *TPL Cost Avoidance*<br>**Report Period:**<br>September 2009<br><br>*Provider Network Adequacy and Capacity*<br>**Report Period:**<br>July 2009 – September 2009<br><br>*PCP Assignment*<br>**Report Period:**<br>July 2009 – September 2009<br><br>*ADRC*<br>**Report Period:**<br>July 2009 – September 2009 | *TPL Cost Avoidance*<br>**Report Period:**<br>October 2009<br><br>*Grievances & Appeals*<br>**Report Period:**<br>July 2009 – September 2009<br><br>*Provider Complaints & Claims*<br>**Report Period:**<br>July 2009 – September 2009<br><br>*Provider Suspensions & Terminations*<br>**Report Period:**<br>July 2009 – September 2009<br><br>*QUEST Financial Reporting Guide*<br>**Report Period:**<br>July 2009 – September 2009<br>***Due Date:***<br>***November 15, 2009***<br><br>*Timely Access Report*<br>**Report Period:**<br>July 2009 – September 2009 | *TPL Cost Avoidance*<br>**Report Period:**<br>November 2009<br><br>*Encounter Data/Financial Summary Reconciliation*<br>**Report Period:**<br>July 2009 – September 2009<br><br>*Medicaid Contracting Report*<br>**Report Period:**<br>Health plan financial year | *TPL Cost Avoidance*<br>**Report Period:**<br>December 2009<br><br>*Provider Network Adequacy and Capacity*<br>**Report Period:**<br>October 2009 - December 2009<br><br>*PCP Assignment*<br>**Report Period:**<br>October 2009 - December 2009<br><br>*ADRC*<br>**Report Period:**<br>October 2009 - December 2009<br><br>*PA Denial or Deferral*<br>**Report Period:**<br>July 2009 – December 2009<br><br>*Translation/Interpretation Report*<br>**Report Period:**<br>December 2009 |

*Unless otherwise noted, reports are due at the end of the month in which it is listed.*

# QUEST MEDICAL 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*<br>**Report Period:**<br>January 2010<br><br>*Grievances & Appeals*<br>**Report Period:**<br>October – December 2009<br><br>*Provider Complaints & Claims*<br>**Report Period:**<br>October – December 2009<br><br>*Provider Suspensions & Terminations*<br>**Report Period:**<br>October – December 2009<br><br>*QUEST Financial Reporting*<br>**Report Period:**<br>Jan 2009 – Dec 2009<br>***Due Date: Feb 28, 2009***<br><br>*QUEST Financial Reporting*<br>**Report Period:**<br>October 2009 – Dec 2009<br>***Due Date: Feb 15, 2010***<br><br>*Timely Access Report*<br>**Report Period:**<br>October – December 2009<br><br>*Over/Under Utiliz of Drugs*<br>**Report Period:**<br>July 2009 – December 2009<br><br>*Over/Under Utiliz /Services*<br>**Report Period:**<br>July 2009 – December 2009<br><br>*EPSDT- Form CMS 416*<br>**Report Period:**<br>October 2008 – Sept.2009<br><br>*Case Management Report*<br>**Report Period:**<br>December 2009<br><br>*Alternate Languages Report*<br>**Report Period:**<br>December 2009 | *TPL Cost Avoidance*<br>**Report Period:**<br>February 2010<br><br>*Call Center Report*<br>**Report Period:**<br>February 2010<br><br>*QA/IP/UMP and Staff Changes*<br>**Report Period:**<br>January 2009 – December 2009<br><br>*Encounter Data/Financial Summary Reconciliation*<br>**Report Period:**<br>October 2009 - December 2009<br><br>*PIP Documentation for On-going PIPs* | *TPL Cost Avoidance*<br>**Report Period:**<br>March 2010<br><br>*Call Center Report*<br>**Report Period:**<br>March 2010<br><br>*Provider Network Adequacy and Capacity*<br>**Report Period:**<br>January 2010 – March 2010<br><br>*PCP Assignment*<br>**Report Period:**<br>January 2010 – March 2010<br><br>*ADRC*<br>**Report Period:**<br>January 2010 – March 2010<br><br>*Translation/Interpretation Report*<br>**Report Period:**<br>December 2009 | *TPL Cost Avoidance*<br>**Report Period:**<br>April 2010<br><br>*Call Center Report*<br>**Report Period:**<br>April 2010<br><br>*Grievances & Appeals*<br>**Report Period:**<br>January 2010 – March 2010<br><br>*Provider Complaints & Claims*<br>**Report Period:**<br>January 2010 – March 2010<br><br>*Provider Suspensions & Terminations*<br>**Report Period:**<br>January 2010 – March 2010<br><br>*QUEST Financial Reporting Guide*<br>**Report Period:**<br>January 2010 – March 2010<br>***Due Date: May 15, 2010***<br><br>*Timely Access Report*<br>**Report Period:**<br>January 2010 – March 2010<br><br>*Case Management Report*<br>**Report Period:**<br>January 2010 – March 2010<br><br>*Alternate Languages Report*<br>**Report Period:**<br>January 2010 – March 2010 | *TPL Cost Avoidance*<br>**Report Period:**<br>May 2010<br><br>*Call Center Report*<br>**Report Period:**<br>May 2010<br><br>*HEDIS CY 2007 Period*<br>**Report Period:**<br>January 2009 – December 2009<br>***Due Date: June 15, 2010***<br><br>*FQHC/RHC Services Rendered*<br>**Report Period:**<br>January 2009 – December 2009<br><br>*Encounter Data/Financial Summary Reconciliation*<br>**Report Period:**<br>January 2010 – March 2010 | *TPL Cost Avoidance*<br>**Report Period:**<br>June 2010<br><br>*Call Center Report*<br>**Report Period:**<br>June 2010<br><br>*Provider Network Adequacy and Capacity*<br>**Report Period:**<br>April 2010 – June 2010<br><br>*PCP Assignment*<br>**Report Period:**<br>April 2010 – June 2010<br><br>*ADRC*<br>**Report Period:**<br>April 2010 – June 2010<br><br>*PA Denial or Deferral*<br>**Report Period:**<br>January 2010 – June 2010<br><br>*Translation/Interpretation Report*<br>**Report Period:**<br>December 2009 | *Grievances & Appeals*<br>**Report Period:**<br>April 2010 – June 2010<br><br>*Provider Complaints & Claims*<br>**Report Period:**<br>April 2010 – June 2010<br><br>*Provider Suspensions & Terminations*<br>**Report Period:**<br>April 2010 – June 2010<br><br>*QUEST Financial Reporting Guide*<br>**Report Period:**<br>July 2009 – June 2010<br>***Due Date: August 30, 2010***<br><br>*Timely Access Report*<br>**Report Period:**<br>April 2010 – June 2010<br><br>*Over/Under Utilization of Drugs*<br>**Report Period:**<br>January 2010 - June 2010<br><br>*Over/Under Utilization of Services*<br>**Report Period:**<br>January 2010 - June 2010<br><br>*Annual Business Transactions*<br>**Report Period:**<br>July 2009 – June 2010<br><br>*Case Management Report*<br>**Report Period:**<br>April 2010 – June 2010<br><br>*Alternate Languages Report*<br>**Report Period:**<br>April 2010 – June 2010 |

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| HCSB Monitoring Activities<br>That Need To Be Scheduled And May Not Require Additional Reporting By The Health Plans | CSO Monitoring Activity<br>That May Be Scheduled |
|---|---|
| • Monitoring claims payment timeliness and payment review policies<br>• Compliance with sterilization/hysterectomy claims payments<br>• Compliance with required language in agreements with subcontractors<br>• Monitoring the plan's contracted provider network<br>• Monitoring of timeliness and accuracy of encounter data submissions<br>• Compliance with HIPAA regulations | • Review of Catastrophic Cases |