



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

October 5, 2007

MEMORANDUM

QUEST MEMO
RPT -0703

TO: QUEST Health Plans

FROM: Lois Lee, Acting Med-QUEST Division Administrator *ll*

SUBJECT: ANNUAL REPORTING AND MONITORING ACTIVITIES
PERIOD: AUGUST 1, 2007 – JUNE 30, 2008

Annually, the Med-QUEST Division's (MQD's) Medical Standards Branch (MSB), the Health Care Management Branch (HCMB), and the External Quality Review Organization (EQRO) assess the quality and appropriateness of health care services. The MQD closely monitors access to those services, 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 August 1, 2007 and continue through June 30, 2008.

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 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.

In an effort to establish a central depository site for tracking of all health plan deliverables, we have designated Ms. Kathy Ramento, kramento@medicaid.dhs.state.hi.us as the key staff member to receive all required reports in hard copy. Please send an electronic version to Ms. Ramento with a "cc" to Ms. Bedelia Hilburn, bhilburn@medicaid.dhs.state.hi.us. Reports will then be distributed to the responsible Branch for review and analysis, including the financial reports.

Clarification of the reporting/monitoring activities is as follows:

General Information:

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 fully been resolved, a comprehensive plan of corrective action including the timetable(s) and the identification of the individual responsible for completing the action is 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 plan of correction in lieu of the 30-calendar day response time.

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.

When the MQD and 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 changes are made to P & Ps, the plans must submit a signed and dated approved copy to the MQD within 30-calendar days of notification. 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 work-flow 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.

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.

Third Party Liability (TPL) Cost Avoidance Report Due Monthly

Requirements: (RFP Section 52.120)

Required 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 are advised to 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. *Reports are due thirty days after the end of the reporting month.* 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 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

Disclosure of Information on Annual Business Transactions Report - Due Annually

Requirements: (RFP Section 52.130)

Required 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
- 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
- Justification of the reasonableness of each transaction

Grievances/Appeals Reports – Due Quarterly

Requirements: (RFP Section 51.710)

Required Information:

The quarterly log of recipient and provider grievances is due thirty (30) days after the last day of the reported quarter.

- Inquiries need not be reported.
- Overturn rates, percentages of grievances and appeals that did not meet timeliness requirements, and
- 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 provider complaints, grievances, and appeals reports in the required Med-QUEST format for all reporting quarters, even when no complaints, grievances, or appeals are logged.

Provider Complaints/Claims Report

Requirements: (RFP Section 51.460)

Required Information:

The health plan shall submit to DHS the following Provider Complaints Reports for each of the quarters identified in Section 51.740. Due dates are also the same as specified in Section 51.740. Reports shall be submitted using the matrix provided by the DHS on the same due dates specified in Section 51.740 in hard copy and in electronic file copy.

- 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 (complaint is expected to be resolved by the reporting date and complaint is unlikely to be resolved by the reporting date);
- A quarterly follow-up report consisting of data elements specified by DHS for provider complaints unresolved in previous quarter(s).
- A quarterly report of delays in claims payment, denials of claims payment, and claims not paid correctly which includes the following:
 - The number of calls from providers received for each month in the reporting quarter; percentage of calls abandoned for each month in the reporting quarter; and average wait time for each month in the reporting quarter;
 - 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;
- 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 Suspensions and/or Terminations – Due Quarterly

Requirements: (RFP Section 51.450)

Reports are due sixty days after the last day of the reported quarter.

Required 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;
- 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. Please indicate if the plan reported the suspended and/or Termination Report to the National Practitioner Databank.

Quality Assurance/ Improvement Program (QA/IP) and Staff Changes – Due Annually (March 31, 2008)

Requirements: (RFP Section 51.610)

Required Information:

- Any changes to QA/IP;
- Detailed set of program goals and objectives that are developed annually and includes 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 QA/IP Plan;
- Written notification of any delegation of QAIP activities to contractors;
- 2008 approved and signed Annual QA/IP and Workplan;
- 2008 Annual Workplan which shall include the PIP-related activities and corresponding benchmarks for the 2008 calendar year; and
- 2007 Annual QAIP Evaluation and if applicable, a separate Annual UM Program Evaluation.
 - HSAG's final 2007 PIP Evaluation Findings and, if applicable, description of the progress to date on the corrective actions completed.

HealthCare Effectiveness Data and Information Set (HEDIS) Reports

Required Information:

New! Med-QUEST will be moving to a calendar year reporting cycle – January 1 through December 31 -- for the QUEST HEDIS reports. To ensure that MQD receives data for all months during this transition from fiscal calendar year to calendar year reporting period, there will be a one-time “catch-up” HEDIS report due this year.

New! Med-QUEST will be moving to a concurrent review period this year.

The HEDIS report covering the Calendar Year 2007 period January 1, 2007 to December 31, 2007 will be due by **June 15, 2008**. The “catch-up” HEDIS report covering the Calendar Year 2006 period January 1, 2006 to December 31, 2006 will be due by **March 31, 2008**. For reference, the period for the last HEDIS report turned in by the QUEST plans ended on June 30, 2006.

Compared to last year's report, this year's report has two new measures added and one measure retired. Also, the measures that have been retired by NCQA have been removed from the list. Below please find the list of measures you will be expected to submit for calendar year 2007. All measures listed below need to be submitted by each plan for 2007.

HEDIS Measures for Calendar Year 2007

I.	<i>Effectiveness of Care 2007</i>
	Childhood Immunization Status
	Breast Cancer Screening
	Cervical Cancer Screening
	Chlamydia Screening in Women
	Beta Blocker Treatment After a Heart Attack
	Comprehensive Diabetes Care
	Hemoglobin A1c (HbA1c) Tested
	Hb1Ac Poorly Controlled (>9.0%)
	Eye Exam (Retinal) Performed
	LDL-C Screening Performed
	LDL-C Screening Level <100mg/dL
	Use of Appropriate Medications for People with Asthma
	Follow-Up After Hospitalization for Mental Illness
	Antidepressant Medication management
II.	Access/Availability of Care 2007
	Adults' Access to Preventive/Ambulatory Health Services
	Children and Adolescent's Access to Primary Care Practitioners
	Prenatal and Postpartum Care
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
III.	Use of Services 2007
	Well-Child Visits in the First 15 Months of Life
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life
	Adolescent Well-Care Visits
	Frequency of Selected Procedures
	Inpatient Utilization -- General Hospital/Acute Care
	Ambulatory Care
	Inpatient Utilization -- Non-acute Care
	Discharge and Average Length of Stay -- Maternity Care
	Births and Average Length of Stay, Newborns
	Mental Health Utilization -- Inpatient Discharges and Average Length of Stay

	Mental Health Utilization -- Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services
	Chemical Dependency Utilization -- Inpatient Discharges and Average Length of Stay
	Identification of Alcohol and Other Drug Services
	Outpatient Drug Utilization
IV.	Cost of Care 2007
	Relative Resource Use for People with Diabetes
	Relative Resource Use for People with Asthma
V.	Health Plan Descriptive Information 2007
	Board Certification
	Member Months of Enrollment by Age and Sex
	Weeks of Pregnancy at Time of Enrollment

HEDIS Measures for Calendar Year 2006

I.	<i>Effectiveness of Care 2006</i>
	Childhood Immunization Status
	Breast Cancer Screening
	Cervical Cancer Screening
	Chlamydia Screening in Women
	Beta Blocker Treatment After a Heart Attack
	Comprehensive Diabetes Care
	Hemoglobin A1c (HbA1c) Tested
	Hb1Ac Poorly Controlled (>9.0%)
	Eye Exam (Retinal) Performed
	LDL-C Screening Performed
	LDL-C Screening Level <130mg/dL
	LDL-C Screening Level <100mg/dL
	Use of Appropriate Medications for People with Asthma
	Follow-Up After Hospitalization for Mental Illness
	Antidepressant Medication management
II.	Access/Availability of Care 2006
	Adults' Access to Preventive/Ambulatory Health Services
	Children and Adolescent's Access to Primary Care Practitioners

	Prenatal and Postpartum Care
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
	Claims Timeliness (Paid / Denied within 30 Days)
III.	Health Plan Stability 2006
	Practitioner Turnover
IV.	Use of Services 2006
	Well-Child Visits in the First 15 Months of Life
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life
	Adolescent Well-Care Visits
	Frequency of Selected Procedures
	Inpatient Utilization – General Hospital/Acute Care
	Ambulatory Care
	Inpatient Utilization – Non-acute Care
	Discharge and Average Length of Stay -- Maternity Care
	Births and Average Length of Stay, Newborns
	Mental Health Utilization -- Inpatient Discharges and Average Length of Stay
	Mental Health Utilization -- Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services
	Chemical Dependency Utilization -- Inpatient Discharges and Average Length of Stay
	Identification of Alcohol and Other Drug Services
	Outpatient Drug Utilization
V.	Health Plan Descriptive Information 2006
	Board Certification
	Member Months of Enrollment by Age and Sex
	Unduplicated Count of QUEST Members
	Weeks of Pregnancy at Time of Enrollment

The reporting template for both reports will follow in mid to late December 2007. 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 both reports prior to submittal to the MQD. If problems or questions are identified by your Medical Director or plan staff, please 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 31, 2008** for the Calendar Year 2007 period and by **April 30, 2008** for the Calendar Year 2006 period.

In the Spring of 2008, HSAG will perform a HEDIS Report Validation Activity which will focus on 6 measures selected by the MQD:

- Childhood Immunization Status
- Prenatal and Postpartum Care
- Follow-up After Hospitalization for Mental Illness – 7-Day and 30-Day
- ER visits per 1000 members
- Children and Adolescent Access to Primary Care Providers
- Initiation and Engagement of Alcohol and other Drug Dependence Treatment

Form CMS 416 Report - Due Semi-Annually

Requirements: (RFP Section 51:510)

Required Information:

In a effort to more closely monitor the screening rates in the EPSDT program so that opportunities for improvement can be identified and addressed in a more timely manner, the MQD requires the Form CMS 416 report be submitted on a semi-annual basis.

The health plans have been previously provided with formatting instructions (QUEST memo RPT-9909). The plans must follow the memorandum instructions and submit the reports on March 1st and September 1st of every year to the MQD. The QUEST plans are required to have these reports reviewed by the Medical Directors prior to submittal.

A formatted diskette can be requested from the MQD if necessary.

Performance Improvement Project (PIP) Documentation Due October 31, 2007; March 31, 2008

Requirements: (RFP Section 51.630)

Required 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, 200*. 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 2007 and the data must be reported by the applicable year separate from the previous year.

Each of our MCOs are in the 2nd or 3rd year of remeasurement of their on-going PIPs, therefore, the MQD staff has decided to add two additional PIP study areas, one of which will be an assigned non-clinical PIP.

- If you are a new health plan, then your requirement is to study the clinical and non-clinical assigned topic areas assigned below; therefore, you will have 2 PIPs in progress.
- The MQD has selected “*Childhood Obesity*” (EPSDT aged member) as the State mandated clinical area of study for 2008.
- The MQD has selected “*Access to Care and Delivery of Services for our QUEST Members*” as the State mandated non-clinical area of study for 2008, which addresses, at a minimum, the following: wait times; referrals and actual delivery of care; and transportation issues-- especially in rural areas.

The MQD welcomes your additional study questions and study indicators as they relate to the assigned study topics of childhood obesity or access to care and delivery of services for QUEST members; however, the MQD is firm on the minimum requirements. Additional documentation submitted to the MQD and HSAG must be reflected on the “HSAG PIP Documentation Tool” and shall include:

- Activity I: Appropriate Study Topic
- Activity II: Clearly Defined, Answerable Study Question
- Activity III: Clearly Defined Study Indicator(s)
- Activity IV: Correctly Identified Study Population

The MQD will work with our EQRO to refine the required study topic, basic study question and minimum study indicators (Activities I - IV) on the “HSAG PIP Documentation Tool,” which will be due October 31, 2007 for **new PIPs only**. HSAG must validate Activities I-IV of the new clinical and non-clinical PIPs prior to implementation of the PIP.

Submission of completed activities for the on-going PIPs (remeasurement cycles) are due March 31, 2008.

Report of Federally Qualified Health Centers/Rural Health Centers(FQHC/RHC) Services Rendered Due Annually (June 30th of each year)

Requirements: (RFP Section 51.440)

Required Information:

The plan must submit a report of services rendered to members of an FQHC or RHC by June 30th of each year, for the prior calendar year (January through December). 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 made to any FQHC/RHC, regardless of whether the FQHC/RHC is included in the plan's contracted provider network. Any capitated payments should also be included.
- 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.

QUEST Financial Reporting Guide Reports – Due Quarterly and Annually

Requirements: (RFP Section 52.110)

Required Information:

Health Plan must submit financial information 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

Encounter Validation Improvement Activities

Requirements: (RFP Section 52.200)

Required Information:

CMS requires states to develop managed care information systems to ensure that managed care organizations collect and report encounter data that are an accurate and reliable reflection of the quality of care provided to Medicaid beneficiaries. Encounter data validation is one of the quality assessment improvement activities that CMS requires states to have validated by an external quality review organization.

The MQD will address details in a forthcoming memo concerning the HSAG encounter data validation study, which is tentatively scheduled in the Fall of 2007.

EORO Activities

The MQD-contracted EQRO activities will be:

- Monitoring health plans' compliance with the Medicaid managed care rules and regulations of the Federal Balanced Budget Act of 1997, including:
 - ✦ Validating 6 HEDIS measures:
 - ✦ ER visits per 1000 members
 - ✦ Children and Adolescent Access to Primary Care Providers
 - ✦ Initiation and Engagement of Alcohol and other Drug Dependence Treatment
 - ✦ Childhood immunization Status
 - ✦ Prenatal and Postpartum Care
 - ✦ Follow-up After Hospitalization for Mental Illness – 7-Day and 30-Day
 - ✦ Validating 4 PIPs (clinical and non-clinical topics per CMS protocol for AlohaCare, HMSA, Kaiser health plans);
 - ✦ Validating 2 PIPs for Summerlin;
 - ✦ Monitoring of QA/PI Quality Standards as directed by the MQD;
 - ✦ Conducting an encounter data validation study;
 - ✦ Conducting an CHAPS 4.0 Adult Medicaid Survey for AlohaCare, HMSA, and Kaiser;
 - ✦ Offering technical assistance to Summerlin in the area of CHAPS survey as they prepare to participate in the 2008-2009 survey cycle.

New Required Reports:

Provider Network Adequacy and Capacity Report – Due Quarterly

Requirements: (RFP Section 51:410)

Reports are due to the MQD thirty days after the end of the reported month. Each health plan must offer an appropriate range of preventative, primary care and specialty services that are adequate for an anticipated number of members and that the network is sufficient to meet the member's health needs.

Required Information:

- Listing of all providers, including specialty or type of practice
- Provider's location
- Mailing address including zip code
- Telephone number
- Prof. 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
- Verification that provider or affiliated provider is not on federal or state exclusions list

PCP Assignment Report – Due Quarterly

Requirements: (RFP Section 51.420)

Each health plan shall submit on a quarterly basis each member's name and PCP to which each member is assigned.

Required Information:

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

Timely Access Report- Due Quarterly

Requirements: (RFP Section 51.430)

Reports are due to the MQD thirty days after the end of the reported month.

Each health plan is responsible for providing timely access to quality care in keeping with stated standards.

Required Information:

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

Prior Authorization Requests that have been Denied or Deferred Report – Due Semi-Annually

Requirements: (RFP Section 51.810)

Reports are due on February 28, 2008 for period August – January and on August 31, 2008 for period February – July .

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

Required 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
- Date and method of notification of the provider and the member of the health plan's determination

Report of Over- and Under-Utilization of Drugs - Due Semi-Annually

Requirements: (RFP Section 51.820)

Required 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.
- 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).

Report of Over- and Under-Utilization of Services – Due Semi-Annually (September 30, 2008; March 31, 2008).

Requirements: (RFP Section 51.830)

Required 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
- 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.

Fraud and Abuse Report – Due Within 30 days of Discovery

Requirements: (RFP Section 51.900)

All incidences of suspected fraud and abuse identified at the health plan level must be reported to the MQD within 30 days of discovery. The required format for reporting is found in Appendix X in the current contract.

Required 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
- Trending and analysis as it applies to: utilization management, claims management, post-processing review of claims, and provider profiling.

Aid To Disabled Review Committee Report (ADRC) – Due Quarterly

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

Required 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";
- Total number of referrals deemed "not disabled" who were then referred back for intensive case management services

Other Monitoring Activities

The MQD will be performing other monitoring activities that may not require additional reporting by the health plans. These activities include, but are not limited to:

- Monitoring of claims payment timeliness and payment review policies;
- Compliance with required language in agreements with sub-contractors;
- Monitoring of the plan's contracted provider network;
- Monitoring the health plan's internal oversight of delegated functions

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.

Please contact Ms. Sherry Balistreri, HCMB or Mr. Alan Matsunami, HCMB should you require clarification concerning any of the reporting/monitoring activities.

Attachments

c: Jolaine Hao
F.G. Dean Rollins
Alan Matsunami
Sherry Balistreri

**QUEST MEDICAL PLANS
MONITORING CALENDAR FOR JULY 2007 – JUNE 2008**

July 2007	August 2007	September 2007	October 2007	November 2007	December 2007
<p>TPPL Cost Avoidance</p> <p>Member/Provider Grievances and Appeals Reporting Period: October '07- December '07</p> <p>Provider Network Adequacy Report</p>	<p>TPPL Cost Avoidance</p> <p>Member/Provider Grievances and Appeals Reporting Period: Aug. 01 '07-Jan. 31, '08</p> <p>Annual Business Transaction report Provider Suspension and Termination Report</p>	<p>TPPL Cost Avoidance</p> <p>CMS 416 Reporting Period: November '07 – February '08</p> <p>Approved 2008 QAIP Description, Workplan, and UM Program Description, if applicable and staff changes. Approved 2007 QAIP Evaluation Due: 03/31/08</p> <p>Documentation for re-measurement of ongoing PIPs: Due: 03/31/08</p> <p>HEDIS ('Catch-up" report) Covering period: Jan 01, '06-Dec. 31, 2006</p> <p>Timely Access Report</p> <p>Report of Over/Under Utilization of Services</p>	<p>TPPL Cost Avoidance</p> <p>Member/Provider Complaints/ Grievances/Appals Reporting Period: July '07 - September '07</p> <p>"HSAG PIP Documentation Tool" Activities I – IV for 2 new PIPs</p> <p>(clinical: "Childhood Obesity", non-clinical: "Assess to Care and Delivery of Services for our QUEST Members")</p> <p>Provider Network Adequacy Report</p>	<p>TPPL Cost Avoidance</p> <p>Quarterly Financials Due date: 11-15 -07</p> <p>CMS 416 Reporting Period: August '07 - October '07</p> <p>Provider Suspension and Termination Report</p>	<p>TPPL Cost Avoidance</p> <p>CMS 416 Reporting period: January 01, 2007-December 31, 2007</p> <p>FQHC/RHC Report Due 6/30/08</p> <p>Timely Access Report</p>
<p>January 2008</p> <p>TPPL Cost Avoidance</p> <p>Member/Provider Grievances and Appeals Reporting Period: October '07- December '07</p> <p>Provider Network Adequacy Report</p>	<p>February 2008</p> <p>TPPL Cost Avoidance</p> <p>PA Denial / Deferred Report: Reporting Period: Aug. 01 '07-Jan. 31, '08</p> <p>Annual Business Transaction report Provider Suspension and Termination Report</p>	<p>March 2008</p> <p>TPPL Cost Avoidance</p> <p>CMS 416 Reporting Period: November '07 – February '08</p> <p>Approved 2008 QAIP Description, Workplan, and UM Program Description, if applicable and staff changes. Approved 2007 QAIP Evaluation Due: 03/31/08</p> <p>Documentation for re-measurement of ongoing PIPs: Due: 03/31/08</p> <p>HEDIS ('Catch-up" report) Covering period: Jan 01, '06-Dec. 31, 2006</p> <p>Timely Access Report</p> <p>Report of Over/Under Utilization of Services</p>	<p>April 2008</p> <p>TPPL Cost Avoidance</p> <p>Member/Provider Complaints/ Grievances/Appals Reporting Period: January '08- March '08</p> <p>Provider Network Adequacy Report</p> <p>PCP Assignment</p> <p>HEDIS (Redone Measures) Reporting Period: Calendar year: 2006</p>	<p>May 2008</p> <p>TPPL Cost Avoidance</p> <p>Provider Suspension and Termination Report</p>	<p>June 2008</p> <p>TPPL Cost Avoidance</p> <p>CMS 416 Reporting period: January 01, 2007-December 31, 2007</p> <p>FQHC/RHC Report Due 6/30/08</p> <p>Timely Access Report</p>

<u>HCMB Monitoring Activities</u> that need to be scheduled and may not require additional reporting by the health plans	<u>MSB Monitoring Activity</u> that may be scheduled
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Review of Catastrophic Cases

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September 28, 1999

QUEST MEMO

RPT -9909

[Supercedes RPT -9908]

TO: QUEST Health Plans

FROM: Charles C. Duarte, Med-QUEST Division Administrator

SUBJECT: REVISION TO EPSDT 416 REPORTING FORMAT

The Med-QUEST Division (MQD) received a memorandum from HCFA dated July 19, 1999, which detailed the new Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) 416 reporting format. The MQD contacted HCFA and was told that this new format is required for the next HCFA 416 reporting period (October 1, 1998 to September 30, 1999).

The MQD has incorporated the new HCFA requirements and previous instructions (QUEST MEMO RPT-9904) into this Memorandum. Therefore, this memorandum replaces all previous directions for the 416 report.

General Considerations:

- The EPSDT report for the next federal fiscal year is due on March 1, 2000 (five months after the end of the federal fiscal year).
- Under separate cover, each plan will receive a diskette in the reporting format. Each plan should submit its report on diskette. In addition, two (2) hard copies of the report should be sent. The diskette and hard copies should be sent directly to Matthew Loke, Ph.D.
- Upon the request of the MQD, plans should be prepared to provide information on how they verify that their providers are performing initial or periodic EPSDT screening examinations, vision assessments, dental assessments, and hearing assessments.
- All Values should be reported to two (2) decimal places.

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- The MQD instructed QUEST plans in QUEST MEMO RPT-9904 that they must redo the October 1, 1997 to September 30, 1998 416 report by August 30, 1999, using the directions in that memorandum. Since those instructions must be modified, to meet the requirements of HCFA, QUEST plans do not have to redo last fiscal year's report.
- Line 1 determines the age groups to which an eligible is assigned. Once determined, the services received by an eligible in the fiscal year should be credited to the age group to which the eligible has been assigned.
- Services should be reported based on dates of service and not payment dates.
- The EPSDT 416 consists of fourteen (14) lines and nineteen (19) specific measures. The reporting period is always the federal fiscal year—October 1 through September 30.
- Clarification of each of the 19 measures are as follows:

Line 1-Total Individuals Eligible for EPSDT

1. All recipients under 21 years of age as of September 30 (last day of the federal fiscal year) must be reported.
2. Recipients must be eligible in the federal fiscal year (between October 1 to September 30).
3. An eligible person must be reported only once even though the person was enrolled more than once during reporting period.
4. Recipients are grouped by their ages of September 30 of the federal fiscal year. The following examples are provided to clarify the age cohorts:
 - < 1: recipients born after September 30, 1998
 - 1-2: recipient born before September 30, 1998 and after October 1, 1996

Line 2a—State Periodicity Schedule.

The State will enter these fixed values based on the EPSDT periodicity schedule in the QUEST RFP. The schedule is as follow:

- Less than 1 = 5
- Ages 1 - 2 = 4
- Ages 3 - 5 = 3
- Ages 6 - 9 = 2
- Ages 10 - 14 = 3
- Ages 15 - 18 = 2
- Ages 19 - 20 = 1

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Line 2b—Number of Years in Age Group

This item is a fixed number and represents the number of years in each of the age groups in Line 2a. The State will insert this value.

Line 2c—Annualized State Periodicity Schedule

This is calculated by dividing line 2a by line 2b.

Line 3a—Total Months Eligibility

This item is the total number of months of eligibility for the recipients in each age group (Line 2) during the reporting year.

Line 3b—Average Period of Eligibility

This is calculated by dividing Line 3a by Line 1, and then dividing the quotient by 12.

Line 4—Expected Number of Screenings per Eligible

This is calculated by multiplying Line 2c by Line 3b.

Line 5—Expected Number of Screenings

This is calculated by multiplying Line 4 by Line 1

Line 6—Total Screens Received

- Use the following procedure codes.

CPT Codes: 99431, 99432, 99381, 99382, 99383, 99384, 99385, 99391,
99392, 99393, 99394, 99395 and/or

HCFA Code: Z9000

OR

- Use the following ICD-9 Diagnosis codes when submitted with valid HCPCS evaluation and management codes directly related to the diagnosis code.

V20-V20.2 and/or V70.0 and/or V70.3- V70.9 with HCPCS evaluation and management codes in the range 99201-99205; 99211-99215

Line 7—Screening Ratio

This item is calculated by dividing Line 6 by Line 5. If this results in a value in excess of 100%, it should be reported as 100%.

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Line 8—Total Eligible Who Should Receive at Least One Initial or Periodic Screen

First, if the number enter in Line 4 is greater than 1, use 1. If the number in Line 4 is less than or equal to 1, use the number in Line 4.

Then, multiply the number from the above calculation by Line 1 and enter this product in Line 8.

Line 9—Total Eligibles Receiving At Last One Initial or Periodic Screen

Enter the unduplicated count of recipients who received at least one documented initial or periodic screen during the federal fiscal year.

Line 10--Participant Ratio

This is calculated by dividing Line 9 by Line 8.

Line 11—Total Eligibles Referred For Corrective Action

This is an unduplicated count of eligibles who were scheduled for another appointment with the screening provider or referred to another provider because of at least one health problem identified during an initial or periodic screen and vision and hearing screening. Do not report health problems corrected during the screening examination or vision and hearing screening examination. The Plan may use the information from the EPSDT form, medical record review, plan specific instructions to providers on the reporting of corrective treatment, etc. to report this item. The Plan should report vision and hearing screening as follows:

To determine if an eligible has a qualifying vision screening encounter:

- Use the following procedure codes:

CPT Codes: 92002, 92004, 92012, 92014, 92015 and/or

HCFA Codes: W9100

AND/OR

- Use the following ICD-9 diagnosis code when submitted with a valid HCPCS code directly related to the diagnosis code.

V72.0 with HCPCS evaluation and management codes in the range 99201-99205; 99211-99215; 9924X; 9925X

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To determine if an eligible has a qualifying hearing screening encounter:

- Use the following procedure codes.

CPT Codes: 92551, 92552, 92553, 92555, 92556, 92559, 92560, 92561 and/or
HCFA Code: V5008

AND/OR

- Use the following ICD-9 diagnosis code when submitted with a valid HCPCS procedure code directly related to the diagnosis code.

V72.1 with HCPCS evaluation and management codes in the range 99201-99205; 99211-99215; 9924X; 9925X

Line 12a—Total Eligibles Receiving Any Dental Service

This is only for QUEST DENTAL PLANS and is an unduplicated count of the number of eligibles receiving any dental service. To determine if an eligible has a qualifying encounter:

- Use the following ADA/HCPCS procedure codes: Z9330, 00100-9999.

Line 12b—Total Eligibles Receiving Preventive Dental Services

This is only for QUEST DENTAL PLANS and is an unduplicated count of the number of eligibles receiving a preventive dental service. To determine if an eligible has a qualifying encounter:

- Use the following ADA/HCPCS procedure codes: Z9330, 00100-1999

Line 12c—Total Eligibles Receiving Dental Treatment Services

This is only for QUEST DENTAL PLANS and is an unduplicated count of the number of eligibles receiving dental treatment services. To determine if an eligible has a qualifying encounter:

- Use the following ADA/HCPCS procedure codes: 2000- 9999

Line 13—Total Eligibles Enrolled in Managed Care

Enter the values in Line 1.

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Line 14—Total Number of Screening Blood Lead Tests

For age groups less than 1, 1-2, and 3-5, enter the number of screening blood lead tests by counting the number of CPT-4 code 83655 used for all ICD-9 diagnosis codes except 984.X (Toxic Effects of Lead and its Compounds), E861.5 (Accidental Poisoning by Petroleum Products, Other Solvents, and Their Vapors NEC: Lead Paints), and E866.0 (Accidental Poisoning by Other Unspecified Solid and Liquid Substances; Lead and its Compounds and Fumes)

Please contact Matthew Loke, Ph.D. at 692-8104 or Lynette Honbo, MD at 692-8106 for questions or clarification.



Med-QUEST Division Administrator